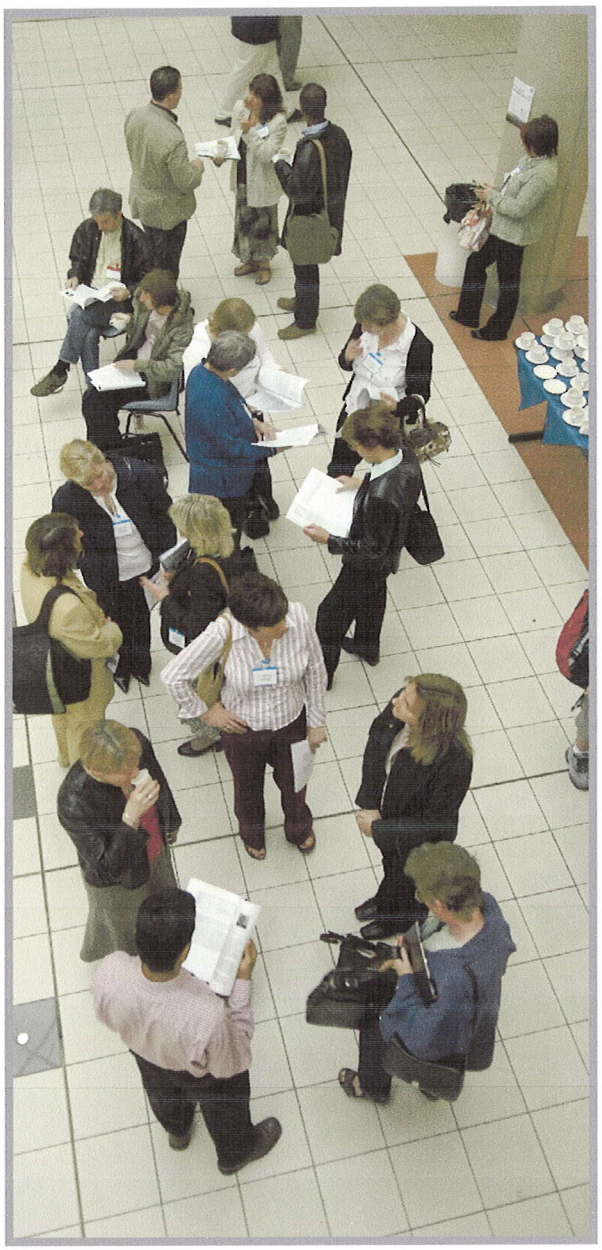
Manchester Metropolitan University

Research Institute for Health & Social Change



Papers from the 2007 RIHSC Annual Conference

"Health & Social Change: Challenges & Controversy"

4th & 5th July 2007
Manchester, UK

Manchester Metropolitan University

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Carolyn Kagan

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Introduction

The papers in this volume reflect some of the diversity of work presented to the Annual Conference for the Research Institute for Health and Social Care held in July 2007. The theme of the conference was:

Health & Social Change: Challenges & Controversy

Strands were: quality of life, disability and rehabilitation, public health and well-being, diversity and social inclusion, cell signalling and disease.

We were pleased to have keynote speakers from Venezuela (Professor Manuel Aramayo) and Norway (Professor Stephen Von Tetzchner). In addition, Caroline Marsh, Director of Adult Social Care, Manchester City Council, Professor Rob Briner, Birkbeck College and Emeritus Professor Terry Looker, also gave keynote talks.

For the first time the conference ran over two days, which were needed to accommodate the 54 seminar presentations and 35 posters, all reflecting the work of researchers in the Research Institute for Health and Social Care. During the conference, a singing for well-being workshop and an art exhibition, displaying some of the creative processes used in our research, took place.

Immediately following on from the RIHSC conference were two further research events: a conference on Advances in Cerebrovascular Disease and a seminar on Disability, discourse and community psychology, took place.

The day before the conference, there was an additional seminar on Alternative Means of Communication.

All in all the RIHSC conference week in July gave a stimulating and energetic experience to the 200 people who attended.

Professor Carolyn Kagan, Director RIHSC

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Through the eyes of children: well-being in the primary school
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Participatory Research Project on Well-being using the Experiential Sampling Method (ESM)
Anne Kellock, Social Change and Well-being, RIHSC, MMU, a.kellock@mmu.ac.uk

In a Present of Freedom
David Haley, MIRIAD, MMU, d.haley@mmu.ac.uk , 0161 247 1093

Exploring play therapists' perspective of change in the therapy dynamic
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Arts for Health and PFI, Invest to Save
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Curator: Anne Kellock, Social Change and Well-being, RIHSC, MMU

Art Exhibition "Tapping into visual worlds"

Book Launch "Well-being: Individual, Community and Social Perspectives"

Participatory Research Project on Well-being using the Experiential Sampling Method (ESM)

Anne Kellock
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Social Change and Well-Being
Research Institute for Health and Social Change, Manchester Metropolitan University

Participatory Research Project on Well-being using the Experiential Sampling Method (ESM)

Following John Haworth's presentation earlier this year on his project: Mind, Technology and Creativity: The Way We are Now, members of SCWB decided to embark on a similar project using the Experiential Sampling Method (ESM).

How the project ran:

The project involves participants using mobile phone camera technology. The phones are programmed to beep a signal at eight random times each day over a seven day period. On each signal, participants are to take a photograph of the main activity they are doing and respond to a series of short questions:

ESM is an innovative method combining photographic images with emotion and cognitive processes as they occur, reducing distortion of memory occurring in retrospective methods and is seen as a complementary method (Haworth, 2007)

Question 1 What was the main thing you were doing?
Question 2 How much were you enjoying the activity? *
Question 3 How interesting did you find the activity? *
Question 4 How challenging did you find the activity? *
Question 5 Were your skills:
1 - less than required by the challenge
2 - equal to the challenge
3 - more than required by the challenge
Question 6 How visually interesting did you find the scene? *
Question 7 How happy were you feeling at the time? *
Question 8 Any other brief comments.

•Questions are answered on a scaled of 1-3 for low, moderate or high





Further details of John Haworth's Project 'The Way We are Now' can be found at:

www.creativity-embodiedmind.com

Participant 5

How to read the posters

Day / Date

The first image at the top poster show the day / date that the column of images were taken on. These range from TV or Internet news with dates evident, newspapers, calendars, diaries etc.

Context 'outside world'

The second image down is to reflect the outside world, this can be anything from a scene outside, to news or weather.

Signal One

The first beep of the day! Signal One will be between 9.30 am and 11.00 am.

Signal Two

The second signal of the day. Signal Two will be between 11.00 am and 12.30 pm.

Signal Three

Signal three takes place between 12.30 pm and 2.00 pm.

Signal Four

The fourth signal of the day. Signal Four takes place between 2.00 pm and 3.30 pm.

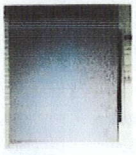
The plain black square denotes a missed signal.

Signal Five

Signal Five will take place between 3.30 pm and 5.00 pm

Signal Six

Signal Six beeps between 5.00 pm and 6.30 pm.



Signal Seven

Signal Seven will take place between 6.30 pm and 8.00 pm.

Signal Eight

Signal Eight is the last signal of each day and takes place between 8.00 pm and 9.30 pm.

Participant 1

Participant 7

Social Change and Well-Being
Research Institute for Health and Social Change, Manchester Metropolitan University

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Thank you to all the SCWBers who took part in this project.

For further details of this project please contact: Anne Kellock a.kellock@mmu.ac.uk

Disabled Students and Social Action: The Social Model of Disability and its application in the Venezuelan Context

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Central University of Venezuela
E-mail: maramayopsi@cantv.net

Introduction

I have come from Venezuela and I am privileged for the invitation I've received to this Congress. Neither Manchester nor its Metropolitan University are strange to me, because of the influence on my professional career after obtaining a Postdoctoral degree on disability, six years ago. It was through this Program that I learned the guidelines of both social action and the social model of disability, which are currently directing my work and will be presented to you as applications that have already been put into practice in my country.

Before starting, I must highlight some general basic issues. Firstly, it should be noted that respect for difference and acceptance of human diversity are two of the principles governing the resolutions of the new Law for People with Disabilities, which is in force in Venezuela. The recognition and acceptance of difference and diversity, among others, lie at the heart of any approach to disability. This is particularly true when the objective is to present an explanatory theoretical model and apply it in a specific context.

Disability is nothing but diversity. It encompasses a wide range of situations, conditions, syndromes, and other circumstances, along with a variety of characteristics and human behaviours. Gender diversity, race, colour, religion, culture and disability are all connected and respect for diversity implies respect for all.

Disability is both a result of and another expression of human nature, which is essentially plural, diverse, heterogeneous, and changing. Such a conception of being human is as valid for university students with disabilities as for any other person. Furthermore, such a conception of what it is to be human is necessary prior to particular considerations of disability, and gives direction to any theoretical explanation or practical action.

Our work requires wider contextualisation. Venezuela is experiencing a process of change. The oil bonanza still remains and uncertainty arises. The nation is polarised and divided. Without wanting to give a political speech, I cannot neglect to mention my country. Depending on the adopted political tendency, it believes in the construction of the so-called 21st Century Socialism or, on the contrary, it is terrified by the actual beginning of an increasing totalitarian system, which, blinded by power, destroys structures and institutions. This situation results in a series of implications for our discussion of disability.

Hopes of change are put into this new law. The country is being bombarded with appeals for the inclusion of historically excluded populations, people with disabilities, afro-descendants, and indigenous minorities. We do agree with the recognition of those segregated groups that have been exploited for centuries, and that have been deprived of their rights, equality, and opportunities. Vindication of these groups as minorities expressing diversity is a matter of justice. Unfortunately, it is through traditional action, and not renewed words, that exclusion continues, perpetuating other forms of discrimination and segregation. Dissident and ideological thinking as well as political differences are not tolerated and end up being discredited. This is not a proper space for a debate on this issue, but it is obvious that the appeal for an inclusive Venezuela remains incomplete: it occurs alongside harmful excluding practices.

I was invited to participate in this conference to share a vision of diversity and disability, and of social action and change, from a Venezuelan perspective. As I see it, this vision was given birth in 1999-2000, inspired by the English social model of disability. Now, it has become a Venezuelan model, thanks to a research project used as a basis for a series of actions and change-oriented programs, in which I was involved since my return from England.

So, how and when have I engaged in this process?

Context of a Move towards the Social Model

It would be relevant to know how I came to the social model of disability. The objective of the Postdoctoral Program, created by Professor Carolyn Kagan and offered by Manchester Metropolitan University, consisted of studying that social model and its implications for Venezuela. It also included the identification of resources for UK university students with disabilities, those mechanisms meant to facilitate enhance their academic achievements, and identify innovative ways to supply support systems.

The postdoctoral program included different academic and practical activities. Among these activities, there was a weekly seminar at the Action Research Centre for Inclusion at Bolton Institute, as well as work sessions at Access Summit, a resource centre for disabled people, with collaboration between the University of Manchester, the Manchester Metropolitan University , UMIST, and the University of Salford. I had meetings with people prominent in disability studies, attended relevant classes at MMU and Bolton, and met with disabled people and some disability organisations.

All this was subject to a weekly critical integration, guided by the Program's tutor.

The Original Social Model of Disability

Through an interesting comparison of models (Oliver, 2005), it is possible to be clear bout the basic premises of a social model:

1) Equality for all citizens. A first class citizenship for all those with and without disabilities.

2) Condemnation of a disabling environment and culture in which the structure and organization of cities, communities, universities and malls is exclusive. It is necessary to fight against this sort of culture! If we take into account that

physical, architectonical, psychological and cultural barriers still exist in England and in the rest of Europe, then what can we expect in South America?

3) The establishment of an emancipatory agenda, meant to promote action and change. This would generate strong challenges.

Whilst there has never existed a single, clear conceptualization of the social model, I was able to understand its essence: the promotion of social action and change, through the organised activity of people with disabilities. The engine that drives social action and change is initiated by disabled people who can not only fight for the observance of their rights, but can also be agents of change towards the construction of a new, inclusive society for all. All thus requires adequate support networks, and must not be limited to the good intentions that usually saturate documents and statements in Latin American congresses, meetings and events, while services remain poor in quality. The social model of disability was understood by me, not as a theory, for, it was never written as such, but as an orientation, and as a catalyst for and coordinator of action. It was not an empty rhetoric, but rather a new philosophy of diversity and the human being. The concept of change as well as its application and practice, both derived from this orientation towards disability, is different in England from Venezuela. There is more pragmatism here: few laws and written documents. This is not the case of Latin America and my country. We have an enormous number of laws and projects written on paper for almost everything. We love written paper, but we are far from putting into practice what has been stated on it! The Social model is a synonym for change. It is also a synonym for an intelligent, decisive and committed social action. At the end of my stay in Manchester and after having visited the Unidad de Investigation Acceso (The Access Research Unit) of the University of Valencia, Spain, I felt I was a connoisseur of the social model. I thought I had been able to understand it not only as a philosophical orientation, but also as an attitude and an epistemological vision of the human being, diversity and disability. For me, this represented more than an academic benefit, for it meant I had acquired a powerful theoretical and methodological tool for the future. It was because of a first academic experience in Keele in the year of 1980 that, 20 years later, I was captivated by the social model. Back then, while studying a master on Mental Challenge and doing an internship at the old Mary Dendy Hospital, I was horrified by the cruelty of the medical model. On the other hand, my wife and I worked in a particular project, in which we dealt with intellectually challenged children and teenagers, for a period of 15 years. In addition, I worked with students with disabilities at the Central University of Venezuela. This experience was completely different from those we had had in England, where we could find innovative materials and publications. This made me understand that placing social aspects above individual ones, redefining the role of professionals, promoting action and social change, strengthening the organized movement of people with disabilities, and seeking a collective identity without the fear of adopting a socio-political vision of disability is a priority. So, with this background of knowledge, I opened my eyes to the Venezuela of the year 2000.

When I went back to my country, I felt highly motivated, and I could not wait to start promoting change through the use of a model that, from my point of view, was innovative, and that I was in the process of internalising. However, Venezuelan reality was disproportionately different. The Vargas tragedy had just occurred. It was a natural landslide that killed over 60.000 people. When I restarted my university duty with the intention of not only being a good professor, but also being an agent of social change, Chavez was barely starting to vocalize messianic promises.

The social model was innovative and interesting. However, as I already mentioned, the way I perceived it did not fit a country that was starting to reach a climax of political and social crisis. The fact that school integration, planned years before, had not yet been put into practice is an indication of this. Importing a foreign model did not seem worthwhile. Conditions and circumstances had little in common, which made it impossible to extrapolate principles, premises and practices derived from the social model. Nevertheless, my decision to start a change remained. The problem was I did not know how to do it.

A second phase took place. Fruitful changes are the result of a proactive vision and not of sporadic individual efforts, unthinking behaviour, or the inappropriate use of experience, valid in other socio-cultural contexts. I will try not to be anecdotal so I can best describe the social action that has taken place during the last 6 years.

Establishing and constructing a Venezuelan social model of disability

1. Creation of Cátedra Libre Discapacidad UCV: A Space for teaching, research and university extension in the field of disability

As an academic, I began to work in the university, which was my closest milieu. A first space for teaching, research and university extension in the field of disability was created. It is the Cátedra Libre Discapacidad of the Central University of Venezuela: the oldest and most important university of the country. It has been designated as "the House that Conquers Shadows" although it pays no heed to people with disabilities.

Despite the fact that some professionals with blindness or motor impairments have graduated since the 1970s, they are survivors of an unequal struggle. There were neither people nor university processes responsible for their admission, support and monitoring. Admission was the only benefit they received from the University. They went through years of struggle and frustration, without having any single sign of support or assistance.

The Cátedra Libre Discapacidad represented an individual (not a collective) response to the indifference shown by university authorities who did not adopt a proposal that included part of the experience acquired in both Manchester and Valencia. It is relevant to reiterate that the objective of my Postdoctoral Program consisted of witnessing different ways of supporting disabled students, in order to learn from them and apply them in my country.

In a climate containing both lack of support by university professors and plenty of solidarity from Psychology students who were barely in the first years of their

studies, the first concrete actions were taken. These included: workshops focusing on people with disabilities: Down syndrome in 2001, autism in 2002, and visual impairment in 2004. There was no official financing for the organisation of such activities. However, there definitely was considerable interest, as indicated by an increasing number of people attending events from 250 to 440, then to 600 people, respectively. This was done through international videoconferences, a tool not widely used at that moment, art festivals showing the talent of some blind students, photography workshops for and by blind people, brochures and publications, video captioning, and the participation of more than 100 volunteer students. Delegations of blind people from Nicaragua, Colombia, Bolivia, El Salvador and Guatemala were present in all these sessions. Most of the participants came from the interior of Venezuela. We had started to translate the social model into actions, although these were rather isolated and dismantled, and had no institutional support, not to mention official aid. Nevertheless, impact on the community was enormous. For the first time, the University was interested in Venezuela's people with disabilities. This was important as the University was well known in the country and was influential in society. The Cátedra Libre Discapacidad-UCV, as it is officially known, obtained legal sponsorship by the University, and progressively became a national reference point. In accordance with the social model, it represented the best space created for action on disability. This is how theory started to be put into practice.

2. Cooperation Framework Agreement UCV - FEVIC.

The Framework Agreement jointly adopted in 2004 by UCV and FEVIC (Venezuelan Federation of Blind Institutions) was one of the first instances of institutional cooperation with a non-university entity. This agreement constituted a strategic alliance with part of the organized Venezuelan disabled people's movement, following the social model. At the same time the university enhanced its access to the community. There is currently a Law of Community Service, compulsory for all university students. Back then, the university precinct was rather an ivory tower, and the academy had no understanding of the needs and problems experienced by its Venezuelan students with disabilities. The inter-institutional cooperation agreement was an accomplishment driven by application of the social model. Instead of learning how to work for or by people with disabilities, what was learned was how to work with them, in a process of mutual learning. Socially-oriented professionals learn much more from the interaction with disabled people and their organisations than from people that have no direct experience in the field of disability. This happens because those who have knowledge about, but no experience of disability, hold only partial knowledge of a complex phenomenon.

3. Research and Construction of the Venezuelan Model.

The social model of disability involves universal concepts that are valid for the United Kingdom, Venezuela, African countries, European countries or any other in Latin America. The recognition of people with disabilities as individuals with rights represents the core of both a philosophical and political vision, and is an issue that has no nationality and no author. In a similar vein, the premises of

inclusive education, which were affirmed in Salamanca 1994 and later documents, are as universal. The social model represents a paradigm for disability. Others (Díaz, 2005) refer to it as a paradigm of complexity or a paradigm of rights (Diaz, 2005). Incongruence becomes apparent when we try to apply the social model in different contexts. We had to dwell on this dilemma from the very beginning of the actions mentioned above. The United Kingdom and Venezuela are two different realities with distinct social, economic, historical, cultural, political, and educational structures. They are rather incompatible in spite of globalisation, of the existing ties between both countries, and also in spite of some common experiences of people with disabilities. In other words, the fact that attention and support services for university students with disabilities in my country were insufficient, and that the authorities were traditionally indifferent, did not represent the real obstacle. Instead, there was a conceptual gap, neither irreconcilable nor incompatible, that demanded much more than a translation from the English version of the social model to Venezuelan Spanish. This was not simply a terminological or semantic problem: the social model needed to be re conceptualised within the Venezuelan socio-historical context. Efforts were initiated in 2001 with an research-action process, involving 11 students from the 2nd through to the 5th year of their studies (all of them from the Faculty of Law and Political Sciences of the Central University of Venezuela), along with 7 men and 4 women ages 20 through 60 representing visual impairment, auditory and physical and motor impairment. Together, they recaptured memories and lived experiences in order to come to understand disability issues from their own perspective. Care had been taken not to bias or influence them, in order to avoid any tendency for socially desirable views being expressed. Whilst they had no formal knowledge of the social model, they could infer some basic notions through their own experience in the University. These included collective identity, the professional role, institutions, and integration. Conceptual, qualitative analysis enabled the recognition of their personal reactions to disability, experienced emotions, and their responses to others with the same condition as well as problems they encountered in life. Through this analysis, the disabled participants' vision of the social model could be identified.

All of them felt disability as an enormous, discouraging obstacle. Economic problems were serious and reflected the country in which we lived (2000 - 2001). Other individual and collective problems were identified: lack of information, lack of sensitivity, discord, rivalry, lack of organization and political-game acts led by the movement of Venezuelans with disabilities. Qualitative analysis made possible the creation of a theoretical model: disability as a concept and socio-historical reality, which included validation of parts of the medical model and highlighted the relevance of the social one. All of the above linked to special needs education, integration and inclusion. . It is pertinent to stress the fact that the study was not based on the social model, but outside from it. Interviewed students had no knowledge of this model. The task was to explore some questions about disability, and to know what the student's personal theory about disability was. Once the study was over, we produced a version of disability that was based on the authentic expression of a group of Venezuelans with disabilities. Comparative analysis allowed the identification of many common issues, which

resulted in the reformulation of concepts in the particular socio-historical Venezuelan context, complete with its own unique features. One of these features was the need for the state – not the Government- to prioritise a focus on disability. In addition to this, validity of the medical model was reiterated as a way to guarantee diagnostic, prevention, early attention and rehabilitation of disability, through high quality services that would promote disabled people as active agents in their own right, as opposed to passive recipients of services. This latter view results in negative perceptions, based on a so called biological inferiority that, in turn results in oppressive practices and perpetuates the excluding disabling culture. Interviewed students called loudly for fervently demanded for a joint evaluation and restructuring of the ha review and restructuring of the health, social and education services in partnership with disabled people. They also demanded an improvement in the service network that was not well organised, as is traditionally the case of most of the Latin American public services. The Venezuelan social model of disability, which is a modest personal contribution, has emerged as a unique proposal. It has resulted from the fusion of concepts originally adopted from the United Kingdom, combined with the Latin American and Caribbean stamp derived from research that was framed in my country. The Venezuelan social model deepens the social vision on the basis of the critical examination of existing resources and services. It demands compliance with the laws that are already in force and for leadership by organizations of Venezuelans with disabilities. It justifies the role of the academy in becoming aware and proactive, in a set of issues of central relevance to it, subsequently transforming both the role and profile of the professionals it develops.

4. Consolidation of a line of research

Actions from the Cátedra Libre Discapacidad-UCV increased. Courses, workshops and joint seminars were undertaken by a considerable number of NGOs and institutions, other than universities. The number of volunteers grew. The University showed a whole different attitude: plenty of solidarity and accessibility. The Cátedra was no longer a small individual effort. It became known as the expression of a different face of the CUV, a face that radiated humanism. Now, authorities frequently refer to it with pride as the *House that Conquers Shadows*. More and more people, as well as institutional efforts have become part of the project. During the last three years, the Cátedra was invited to most scientific events about disability that have been held both in Caracas and the interior of the country. As its Coordinator, I seized every opportunity to diffuse the Venezuelan social model of disability: a model that is continuously being enriched by additional visions and contributions. Today, the Cátedra, is becoming an institution. The team works to eradicate the emphasis on individualism and fails to leave any traces or continuity of actions within a culture that is not collective or communal. Emphasis is put into the accomplishing of institutional achievements. Research that had formerly been undertaken in pursuit of the achievement of personal academic objectives has been turned into a research line of the Faculty of Humanities and Education. At the same time, there has been a rise of interest in disability in the country. This

issue is not subject to this presentation; however, it certainly explains increasing initiatives in the field of disability. One research project was entitled 'Students with Disabilities of the Faculty of Humanities and Education, CUV. Research Contributions' (PG 07-00-5814-2005). It was financed by the Council of Scientific and Humanistic Development of the Central University of Venezuela (CDCH, UCV), which is a body dedicated to support research, scientific events, and publications. 15 research projects within undergraduate and postgraduate programs were conducted at CUV and other Venezuelan universities. These projects focus on the students with disabilities at the Faculty of Humanities and Education-CUV, and examine the attitudes that other students, teachers and their closest community have towards them. They also explore studies with blind and deaf people, and on primary school teachers. As a result, a new form of learning has taken place in the University, thanks to the consolidation of a research line. The social model was the main conceptual component in the theoretical framework of all the different research projects.. Concurrently, an individual research project was developed, called: 'Venezuelan Network of Support to Disability: Service Directory, a contribution by the CUV. (PL-07-00-5814-2005). Even though the project was undertaken successfully, lack of financial support has prevented the materialization of the directory. M It is intended to produce the information in a directory format, such as a telephone directory, for institutions, associations, professionals and individuals requiring services in the country. This research is not strange to Manchester. It builds on, albeit suing different concepts and in different circumstances, the 'Support Network on Disability: A Resource Guide to Disability Groups and Organisations' that I produced in 2000 (Aramayo, 2000). Today, three different doctoral theses from different universities have initiated a new research phase, integrating the social model, inclusive education and other lines of work.

The countrywide proactive presence of the Cátedra Libre Discapacidad-UCV at the events focusing on disability-related problems, and the consolidation of a line of research on disability has made the internalisation of the social model possible. This has been done through the incorporation of new elements, leading to an understanding of it as a model that is deeply rooted in the context and circumstances of the country. The universal concepts from which the social model derived remain valid. Venezuelans, including the new defenders of the model - professionals from the team - have the task of transforming it as a theoretical and methodological means for achieving a common purpose: the construction of an inclusive Venezuela.

5. Books and Publications.

The differences between the social and the medical models was first examined in Venezuela through a theoretical integration, prior to the research mentioned above, and published as a book, ' La persona con discapacidades y su familia: Una evaluación cualitativa' (Disabled people and their families: a qualitative review) (Aramayo 2001). A second book entitled La Discapacidad: Construcción de un modelo teórico venezolano (Disability: Construction of a Venezuelan Theoretical Model) (Aramayo, 2005b) examines a particular questions related to disability. a) Who defines it? b) What are the societal attitudes and responses, the models and

the theories regarding the explanation of disability? The book is a documentary work on people's incapacity to define their own disability, and the historical sense of both human attitudes and responses. In it, the medical and social models are tackled through the exhaustive analysis of some of Mike Oliver's expositions. This is followed by a description of the research that involved the 11 students. The book finishes proposing a specific characterization of a Venezuelan version of the social model. Finally, Universidad y Diversidad (University and Diversity) (Aramayo, 2005b) is another relevant publication. It begins with a vision of the social model by emphasizing the interaction between several factors such as the legal framework, policies, concrete plans and programs, leadership by organised groups, institutions, professionals (including standard teachers playing a new role), the establishment of support network, family, and the community. The book is an account of the experiences gained, up to 2005, based on the social model. Subsequently, the initial theoretical considerations fused with actions undertaken in pursuit of a specific Venezuelan social vision.

This vision emerged from marches and countermarches stemming from a tense red-hot controversial political process that demanded, among other things, a debate on the issue of Venezuelans with disabilities. Disabled people progressively took more and more active roles, becoming the main actors in the management of their own situation. Those were the years in which the new law was first written and discussed.

6. Center for Attention to Students with Disabilities at the Faculty of Humanities and Education: UNIDIS-FHE

We have embarked upon a series of concrete actions derived from a philosophical and programmatic posture - the social model. Success has not always been the rule. Contradictions between those in charge of decision-making have always existed and always will: on the one hand, university authorities, and, on the other, the senior officials at the Ministry of Higher Education. Both groups define the guidelines of education policies, influenced by ideological and political interests and priorities. But I have to mention a project that is in progress. It is a project that involves action favouring students with disabilities in Venezuelan universities, and that has been guided by my experience in Manchester. Despite an unsuccessful start, in 2006 it became the Unidad de Atención a los Estudiantes con Discapacidad (UNIDIS-FHE) (Unit for Students with Disabilities). It is not as impressive as all those services and resources found in ACCESS-SUMMIT in Manchester, mainly because of substantial structural and financial differences. However, in an effort to emulate ACCESS-SUMMIT, a service department was created. It offers the following programmes: 1. Establishment of a legal framework, 2. Access 3. Admissions and support service for the guidance and monitoring for students. 4. Technology service for students, 5. Awareness-raising and training of teachers 6. Cultural project 7. Research and publications. 58 students with disabilities from the Faculty have begun to benefit from these services. More professors and heads are joining this project. Students are now assuming an active role, leaving behind the traditional attitude of asking for everything without a minimum effort.

'Divinest Sense': some social, literary and philosophical considerations of arts practice in mental health work.

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The title of this paper – Divinest Sense -comes from a lovely poem of Emily Dickinson's. It captures the arbitrariness of what we designate as mad or sane, the anxieties that such labels engender in us, and the strength of the social pressure to conform which springs from our fear of difference. The glory of the poem is, of course, that its creativity acts as a wonderful balm for our fears.

Much Madness is Divinest Sense
To a discerning Eye
Much Sense the starkest
Madness
'Tis the Majority
In all this, as All, prevail
Assent and you are sane
Demur – you're straight
Dangerous
And handled with a Chain.

Emily Dickinson was of course, pretty eccentric, as were John Clare, William Blake, Robert Schumann, Richard Dadd, Alexander Scriabin, Van Gogh, Virginia Woolf, John Ogdon – these are just names off the top of my head,- but they give us a pretty accurate indication of the immense cultural debt we owe to those with enduring mental health problems. These people – and many thousands like them - had that 'Divinest sense'.

I am a trustee and sometimes volunteer for a small charity, ARC - Arts for Recovery in the Community – based in Stockport, Cheshire. We exist, I think in part, to promote that 'Divinest' sense in all of us, mad or sane. It was started by a visionary, community artist, Michael Anderson, and we look for ways to break down barriers between people, whatever their psychological, medical or social status. ARC does this largely through the encouragement of the creative imagination. Our members all have experienced mental health difficulties of one kind or another and we are part of the developing movement which uses arts practices in mental health work. There is now a sizeable body of evidence, from across the world, to testify to the therapeutic and beneficial effects of fostering well-being through creative, imaginative practice. This paper is an attempt to examine some of the social, literary and philosophical issues which arise from this kind of approach. My thinking has

been prompted largely by reading Kant's late work, *The Critique of Judgement* and by looking again at the first and last sections of Wittgenstein's *Tractatus.*

a) Social
The most obvious justification for arts practice in mental health work is the social policy approach, which is about inclusion and exclusion, keeping people out of hospital, improving life skills, giving back self-confidence, enabling people to take control of their lives a bit more and of offering pathways to other exciting things that contemporary living can offer. These are very laudable and genuinely moral aims, and at ARC we take them very seriously. We are strongly communitarian in our outlook, both in our own organisation itself and in our relations with the public world.

We work in a large open studio with members and staff wandering freely about, striking up conversations as need arises. There is also a quieter Learning Lounge with easy chairs in which people can usually be a bit more to themselves, if that's what is required. There are some structured sessions – on writing, life drawing, painting, photography, film-making etc. and there are 'open studio' days where members carry on with their own work. What one sees most days, is simply groups of people quietly and purposefully getting on with practical activities. It doesn't look very different from what you would expect to see in a Fine Art studio in a university – except perhaps that there would be rather more work going on at ARC, and we would have started a little earlier than mid-afternoon.

The sense of an arts *community* is very strong, with members helping each other in quite a spontaneous way. That has now become part of the ARC culture. Everyone knows that the other members present have all suffered some kind of mental trauma and that is respected. It produces a very strong and creative sympathy between members and fosters a sense of inclusion and worth, simply by their being active in such a creative organisation with many like-minded people.

We do also, of course, hold public exhibitions of our work as often as practicable. These might take place in our own space, with the public invited in; or they may take place in public spaces such as art galleries, universities, community centres, libraries parks etc. These too are very important. The

public display of creative work binds together the outer busy social world, with the inner, private creative world of the artist. There is then some overt, public recognition of the mentally ill as valuable persons. The many exhibitions we hold feed back to our artists this genuine sense of their own worth, which can then be taken in as part of the core personality. Being of value is therapeutic for all of us. Being undervalued damages all of us. In that respect, the recovering and the recovered are as one.

Through the public display of privately conceived visions and texts, our artists then see themselves as part of a much broader, creative community. Recently, we have teamed up with Reddish Community Gardens for a Lottery funded project called *Grow and Behold,* where gardeners have introduced our

members to the joys of digging, hedging and harvesting and we have introduced them to the delights of poetry, painting and Photoshop.

This bringing together of two quite distinct communities has proved very fruitful, in more ways than the literal one of having something nice to eat or look at. Exhibitions have been held both in our own space and in the public arena of the Community Garden itself, and the whole exercise embodies this bringing together the inner and outer worlds of experience, into one shared, creative, and practical act. Here, art practice gives meaning to existence, both in its individual form and its location within a community. It unifies a part with a whole, and that, according to Kant, gives us a deep satisfaction and underpins our experience both of nature and art.

b) Literary

A second kind of approach towards mental health and arts practice, that might be helpful, is perhaps a literary one. The development of language skills through aspects of creative writing seems to give our members a more efficient framework for recognising and defining their emotional and existential states. There are many precedents in the literary community for mental illness being a recurring factor amongst writers. Dryden's famous epithet from *Absalom and Achitophel* that "great wits are sure to madness near allied", seems to be borne out by contemporary medical research. According to N.C. Andreasen, over 80% of 'creative writers had a major mood disorder.' (1). Kay Redfield Jamison, of Johns Hopkins University, argued in her study *"Touched With Fire: Manic Depressive Illness and the Artistic Temperament"* that among distinguished artists depressive illnesses are 10 to 30 times more prevalent than in the population at large. (2)

Shakespeare clearly had a lot of experience of mental health issues, especially I suspect around the period of the great tragedies 1599-1605. *Macbeth* and *Hamlet* and *Lear* on one side and *Twelfth Night, Much Ado* and *Merry Wives* on the other, suggest something of a bipolar personality. In the figure of Lear's Fool and in some of the later plays, he certainly seems to be able to write of what we would now call schizophrenia. This is Caliban on his voices:

> The isle is full of noises,
> Sounds and sweet airs, that give delight and hurt not.
> Sometimes a thousand twangling instruments
> Will hum about mine ears, and sometime voices
> That, if I then had waked after long sleep,
> Will make me sleep again: and then, in dreaming,
> The clouds methought would open and show riches
> Ready to drop upon me; that, when I waked,
> I cried to dream again.
> - *The Tempest, Act 3, Scene 2*

That seems to offer us a vision of the world that all of us at some time, and schizophrenics perhaps more often, sense; a world that is just beyond our reach, where voices come to us with either beautiful or terrifying visions.

My friend JP has been a member of ARC for some years and the language and creative writing work there seems to have given him some comfort and reconciliation with his voices. It has also given him the confidence to use, in ordinary conversation, the highly original literary imagery which pops into his consciousness as part of his illness. These are just a few of the expressions that came up recently, as we sat drinking in the pub:

Of the camaraderie amongst the mentally ill at ARC:
"we have a common understanding, like prisoners on a beautiful island."

On the damaging effects of schizophrenia:
it marks " the circumference of their lives."

On voices:
"The snag is, which one is God's voice? Which are the good voices and which the bad? They all *sound* pretty much the same."

On his dog Mitzi:
"I'd carry her soul beyond the heavens."

On life generally,
"The art of living is facing death."

These are insights which would not be out of place in a university, yet John has very little formal education, was an unrecognised deaf child, and left school at 15. He certainly doesn't read what might be termed 'literature', however defined. The confidence, with which such phrases are now used by him as part of his normal discourse, is a testament to that therapeutic quality

which the creative writing, undertaken at ARC, gives to its members. It reduces *alexythimia* - the difficulty of putting words to an emotion, or even not having any words for what you are feeling. (For an interesting discussion of this topic, see Joyce McDougall, *Theaters of the Mind,* Chapter 7.) (3)

In a way, all art work is about accommodating to our inner voices and outer visions, and making them both manageable and constructive. This as an essential part of the work the creative artists and therapists at Arts for Recovery in the Community do. Refining and stretching the limits of language so as to better encompass our experience, remains one of our most effective strategies for producing a sense of well-being in our members, and indeed in the population at large.

c) *Philosophy*

There is perhaps a third kind of answer, a philosophical approach, to the riddle of this connection between creativity and mental illness. ARC's work does have a religious or spiritual quality to it, - Emily Dickinson's spark of the divine, is found pretty often there. However, as an atheist, I always find this kind of answer quite difficult to deal with. Yet, somehow, inwardly, I'm convinced that this 'spiritual' aspect of all our creative work is just as important as any of the very real social benefits which come from working in the arts. It is also much more philosophically interesting. Working in an arts community is about defining what the larger 'human community' is, and exploring how an arts community can be made to transcend cultural, class and health differences. Somehow, we can see this at ARC where people are struggling with all kinds of very real difficulties - but equally, are transcending them. It was perhaps this notion of transcendence which made me return to Kant and the early Wittgenstein as starting points for an investigation.

Kant is a truly great thinker and has a vision of the architecture of the mind in *The Critique of Pure Reason* that is still fruitful and worthy of study. His later work, *The Critique of Judgement*, written when Kant was in his seventies, is understandably less comprehensive and, at times, is both repetitive and confused. No one ever accused the even the younger Kant of writing with any great clarity, but the terminology used in *The Critique of Judgement* seems particularly slippery and difficult. Kant employs a variety of inter-changeable terms for the same concepts that makes the reader's task especially arduous. However, I feel there are passages of real insight into creative practice and aesthetic judgements in this later work which do bring some rewards. Although I am not a Kant scholar, I offer what I think are the bones of the arguments which might be relevant to work in arts therapy.

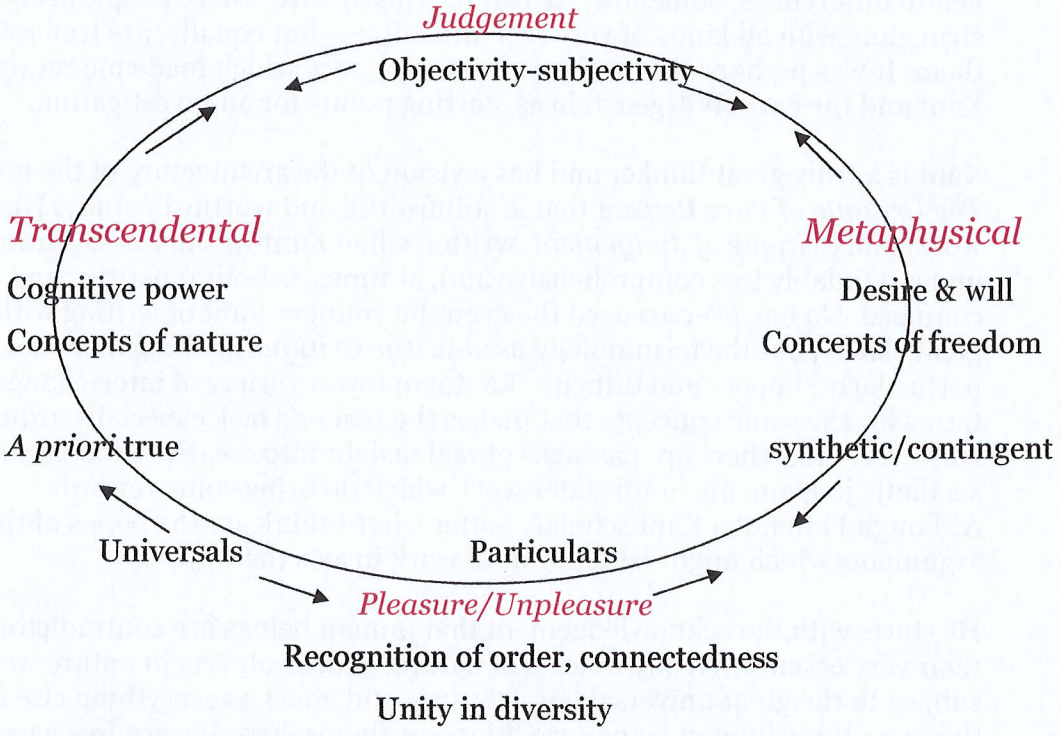
He starts with the acknowledgement that human beings are contradictory in their very essence. We are objects in nature, and, as objects in nature we are subject to the great universal laws of cause and effect as everything else is. At the same time, human beings are things-in-themselves. We are free agents. We can be prime causes, or causers. We can will events in the world and we can do this spontaneously, on a whim, if we so choose. We can act in the world under no other compulsion than our own desire. We are creative, and the evidence for our freedom is shown in that exercise of creativity. We place things that are flimsy and nebulous – our desires and ideas – into the world of

solid things and facts. We are in continuous inter-change between the inner and the outer worlds of experience. In that way, we have both earthly and god-like qualities, qualities which are, in Kant's terms, firstly metaphysical and secondly, transcendental. The former – the metaphysical - are the stuff of our daily lives; the latter - the transcendental - we can never fully know.

Kant argues that if we are to have experience at all – any experience – we need these two sources of concepts. The transcendental, he calls 'natural', by which I think he means the great laws of nature,– like every event must have a cause. These he argues are *a priori* true. He also calls these 'analytic' concepts, and they would be true for any universe we could think of.

The second set of concepts – the metaphysicals - he calls the concepts of freedom. These we have when we desire and act. He labels these 'practical', or sometimes 'contingent', or 'synthetic' concepts. These are true of our particular lives and this particular universe. (4)

What I think Kant argues for, is that both these kinds of concepts must be applied to "the sum total of the objects of all possible experience", if we are to have experience at all. (p 13) He then goes on to argue a much bolder claim, that in art practice and in art judgement, these two conceptual movements are bound together, in the creative act and the creative judgement, and this gives us the deepest form of pleasure. I think he visualises the creative process rather like this:



Where intellectual or creative reason and judgement are used – particularly in the recognition of form – there is a direct effect on the body and on our health. (See section 54,331, p.201) He tells some pretty awful jokes – rather confirming our racist prejudices about German humour – and shows that it is the recognition of *play* in the form of a joke, which raises tension and then

releases it to nothing. That makes the body laugh spontaneously and that process of controlled tension and release makes us healthier. Humour, music and gambling (interestingly) are the three practices he cites which have this playful, contradictory structure. In a joke, it doesn't matter if it is an Englishman, Irishman or Scotsman, or an Ostfrissian, Prussian or Hanoverian, who form the nexus of the narrative; the play in the logical form of the joke is all. We are not actually interested in the content, but only in the intellectual structure of the joke, since that is what gives us bodily pleasure through this tension management and release. He then argues that it is this stimulus of an intellectual pleasure – coming from reason and judgement, - which then "furthers all the vital processes in the body." (p. 202) If we understand a joke, a piece of music, or the strategy in the winner of the 3.30 at Kempton, then what we do is put together very disparate elements of the outside world into a willed form of unity in our cognition. The energy and impetus of these bringing- togethernesses (sorry about the Kantian compound noun), springs from the imagination and the mind, but it is about things which happen outside us, in the real world, in the social situation of the joke, in the orchestra, or on the race track. That's what we have made a whole of. We have derived a unity from a combination of inner and outer experiences. Our creative mental and physical acts, bind together inner and outer worlds into a willed unity of experience and this makes us feel well. Kant goes on to argue, that this is because "the soul is the physician of the body." (p 202) Interestingly, for as early as the eighteenth century, he gives the primacy to our mental life as the key driver for our overall sense of well-being. Health comes from binding together as one, our imagination and some important aspects of our practical living. That is what the expressive arts do by their nature.

This is true of course, even when there is no specific intention to produce health. No bookie ever made his fortune by altruistically considering the welfare of his punters. But in arts practice, there is always intention; there is always the good will. And in nature, there is always purposiveness; there is always a reason why things happen. So these health-giving properties that are generated by humour, music and the pleasures of horse racing, are greatly reinforced when we come to consider the application of willed, creative practice to our own lives and activities.

Kant argues that, because we are things-in-themselves as well as objects in nature, we are truly free only when we *choose* to act, when we act with a good will. It is through his central idea of freedom, of humans as freely acting, rational beings, that we can experience beauty – and without beauty, Kant argues, reason is incomplete. That is his interesting justification for creativity and art, that we are not fully human without it. It is why all human cultures produce art – from cave drawings to hip-hop. We exercise our ultimate freedom and our true nature, when we create. In painting, each single brush stroke is an example of that choice being made, of the good will being exercised. I think it is this act, uniting the inner and the outer, which makes us feel better, more 'whole' whenever we paint/write/make music/dance etc. Creativity is, by definition an act of our freely chosen will.

It is through creativity that we move towards a sense of approaching the transcendental. Kant here calls it the 'supersensible', as well as the more usual, term the 'numinous'. He means by it, the things that lie behind appearances, which actually cause appearances. These things, logically, we know we can never know. As humans, it is not ours to experience the numinous, the supersenisble. We are not, and never will be, equipped to get there, since all our experiences come through the senses. That is our tragedy, and indeed, the tragedy for any being which relies on sense apparatuses for knowledge. The senses can never get us beyond the realm of appearances and into the realm of the supersensible. (p13). However, we do get pleasure from the attempt. It is part of our spiritual longing. And by pleasure here, I think Kant also means that sense of wholeness, the recognition of our being a thing-in-itself, which can make judgements and put new things into existence. It is a god-like power. We do not simply exist as objects subject to random forces over which we have no control. The creative act is the closest we can ever come to that 'Divinest sense' of Emily Dickinson's. But equally, it is a part of our birthright.

This dual movement, backwards and forwards between the transcendental and the metaphysical, the analytic and the synthetic, is also reflected in language. In evolutionary terms, gods come into existence with the human capacity for speech. Before Logos, there is nothing of the divine that can have existence or be expressed. When we create now, after perhaps 100,000 year or so of language, we are trying to re-capture something of that movement when Logos – to counter Pandora – brought everything of a chaotic and purposeless nature into *life*, i.e. into set ordered events. It is through language that we became part of a rational universe, a universe that goes to fixed laws that we can, and do, discover. That is the movement that I think both Kant and the Wittgenstein of the *Tractatus*, are trying to talk about. Language, and therefore experience, has clear limits when it tries to approach the transcendental.

The relationship of language, thus viewed, with mental illness, is that the experience of extreme mental distress, is rather like the world before language. When you are ill, events seem to be random. There are snippets of other voices appearing to come into you from nowhere. You are overcome in a meaningless way, by different and often contradictory, extreme moods. All these events seem – indeed are - outside your own control. You recognise that you are still an experiencing subject, but that subjectivity appears to have no willed connection with events outside yourself. There is nothing creative of your own which can bind together inner and outer experiences and make something unified of them.

Wittgenstein, like Kant, recognises that we are never going to understand the transcendental aspects of being a living thing, which has experiences. 'The sense of the world,' he argues in that last great section of the *Tractatus* 'must lie outside the world' 6. 41.(5) He's like Dante in the final canto of *Il Paradiso*, where, when confronted with the face of God, language cannot express what it experiences.

...A l'alta fantasia qui mancò possa;
ma già volgeva il mio disio e il velle,
sì come rota ch'igualmente è mossa,
l'amor che move il sole e l'altre stelle.

Here, high fantasy broke down;
but my desire and will were moved already
like a wheel, revolving uniformly,
by the love that moves the sun and the other stars.

(Dante, *Il Paradise,* final canto 33, ls.142-45)

For Wittgenstein, "It is not how things are in the world that is mystical, but that it exists." (6.44). He goes on:

6.522 There are, indeed, things that cannot be put into words. They make themselves manifest. They are what is mystical.

7. What we cannot speak about we must pass over in silence.

Art practice is about making things manifest, even if we do not know what those things are and cannot fully understand them. They are what makes us, however fleetingly, feel whole.

The human community begins with the first acknowledged utterance. When we invented and started using language all those years ago, we rather foolishly gave back the idea of our own creativity to gods, to beings outside ourselves. We forgot, or disavowed, the fact that every speech act, and the mysterious thought that goes with it, is an example of continuous creativity, of putting something of inner-selves into the outer- world, and making that world through the act of speech. Each human sentence is newly created, unheard of and unexistant, before its utterance. I might have made this point before to students, but I will have never made it in quite the same way, with the same intonation, in the same circumstances. Time and space will, by their very nature, make it different, even if I tried to keep it the same. The miracle of language also carries with it of course, the hope that other people will understand the sentences as they come out, freshly minted. Other speakers will make them part of their world, despite never having heard them before. There will be a connection made between the speaker's will and a community of hearers. Language is indeed miraculous. Art practice embodies that miracle. In Wittgenstein's words, it makes the mystical 'manifest'.

Creative communication therefore becomes important for human beings, mad or sane, because the spark of our uniqueness lies in each of our speech acts, whether the voices come from inside or outside. It lies also in each concentrated stroke of a brush on the canvas, or the click of a shutter in the camera. Willed creativity makes manifest the experience of beauty, without which, we are incomplete. It binds together the recovered and the recovering, into a 'community of rational beings', which Kant chooses to call the 'mystical body'. It is where the Kingdom of God becomes the Kingdom of Ends. It is enough.

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Embodied Ecology, Symbiotic Futures, Questions of Survival

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1. Que sera, sera

Sung by Doris Day in the Alfred Hitchcock's 1956 film, *The Man Who Knew Too Much*, this song touches one of humankind's most deep-rooted preoccupations – the future. Or, fear of the future, because as the song suggests, 'the future's not ours to see'. It suggests uncertainty, beyond our ability to consider the odds and take risks. As F. David Peat, in his book *From Certainty to Uncertainty: The Story of Science in the Twentieth Century* writes:

> "Quantum theory introduced uncertainty into Physics: not an uncertainty that arises out of mere ignorance but a fundamental uncertainty about the very universe itself. Uncertainty is the price we pay for becoming participators in the universe."

And yet the the Nobel Lauriat in Chemistry, Illia Prigogine celebrated the fact that the future is not predetermined. He wrote;

> 'The inclusion of irreversibility changes our view of nature. The future is no longer given. Our world is a world of continuous "construction" ruled by probabilistic laws and no longer a kind of automaton.'
>
> 'We are led from a world of "being" to a world of "becoming".[i]

In a journal article on Art and Ecology, I wrote in 2003, I posed the following question:

> 'From space, looking back at earth, we may see three key issues: the accelerating increase of the human species, the accelerating decrease of other species and the accelerating effects of climate change. We might ask how we are to cope with these changes creatively?'[ii]

How will I and those I love survive the accelerating effects of climate change?

It is probably too late to consider Sustainable Development as a viable concept, so what are our possible futures? How might creative notions of re-invention, adaptability and resilience make new forms of well-being?

2. Ecological Principles:

Among other words we get from the Greek word, *oikos,* meaning house or dwelling, we get 'ecology', or the study of organisms, their relationship to each other and their relationship to their environment. But the principles of 'whole systems ecology' include:

- Diversity – species richness across whole systems

- Interconnectedness – interdependence
- Finite resources – as in non-equilibrium thermodynamics and entropy
  WIGIG ('when its gone, its gone') and Time

3. Embodied Mind / Embodied Ecology

According to Lakoff and Johnson's studies into 'the embodied mind'[iii], based on second generation cognitive science, bodies and brains together, not separately. And, by the same token, I would ague that we should consider the concept of our 'embodied ecology'. We evolved as an integral part of the whole environment, not separately from it. Interconnectedness and interdependence are central to understanding whole systems ecology, its one of the key principles of the Deep Ecology Movement.

4. Symbiotic Futures

"There is a common folk theory of evolution, that evolution is a competitive struggle to survive and reproduce. The folk theory has normative implications: Competitive struggle to survive and reproduce is natural. Moreover, it is good, because it got us where we are."[iv]

However, a key factor in evolutionary development was when one (mitochondria) cell entered another to live symbiotically. Two cells living as one organism, completely dependent upon each other, not just for their existence , but for their potential to become multi-cellular organisms.

Culturally and socially we may come from different pasts, and we are brought together in the present to view the future. Not one future but many diverse futures – each dependent on the other. One of the authorities on Foresight thinking, Richard Slaughter writes:

'Integral Futures, thus, does not take a singular perspective; rather it recognises a plurality of perspectives. It is not confined to a single tool or methodology; rather it is aware of the existence of an entire (indeed, infinite) tool kit. It recognises that there are many ways of knowing – many paradigms, practices and methodologies of knowledge seeking – and that no single paradigm can be assigned pre-eminence ... Integral Futures welcomes, embraces and values all careful and sincere approaches to knowledge seeking in all spheres of human activity to which they are both appropriate insight and spirituality.[v]'

5. Re-invention and adequate – including analytical rationality, intuitive

Living things need to re-invent themselves to stay alive. As dissipative structures, far from equilibrium, our cells know how to reproduce through autopoiesis[vi], or self making. Now, as an artist, I find the idea of this capacity for making, or creating very interesting. Indeed, the root of the word Art is ***rt*** . Coming from the Indian ***Rg Vedas***, it means the dynamic process by which the whole cosmos continues to create itself, virtuously.

6. Adaptability

With regard to surviving climate change, mitigation is important for the future, but our current weather is based on conditions thirty years ago and the accelerated release of carbon dioxide and other greenhouse gasses from the past thirty years will bring further unprecedented acceleration of the effects of climate change. So our ability to adapt is of equal importance. And keeping the discourse plastic is one measure in this. But how might we engage?

Well, I would suggest that you can **join the discourse** anywhere, any time. The important thing is to be in it. Art may be a good means to **change cultural metaphors** regarding development and progress? If so, we might **shift the narrative** from a limited future choice to a myriad of futures opportunities.

I suggest this is a creative activity that is itself concerned with a form of aesthetics – all art is concerned with telling stories of one sort or another.

7. Resilience

In critical futures studies the concept of resilience is gaining importance. And there is emerging the notion of two predominantly different definitions of resilience. The first, '**engineering resilience**' refers to designing our future for duration, 'sustainable development', if you like – maintaining the status quo. But this type of resilience may not be necessarily be good for everyone. Slavery and desertification are less desirable manifestations of this form.

Then there is '**ecological resilience**'. At first, ecological resilience seems to be a very depressing option, as it is concerned with our ability to survive collapse. This form takes its lead from the concept of evolutionary perturbation – how certain species survive big shocks to their system. It's actually not about focusing on the doom and gloom of disaster, it looks to making it through and beyond – projecting through collapse to possible futures. And the notion of re-invention, I mentioned earlier sets the evolutionary precedent here.

8. Well-being

The question then remains, 'how might we achieve this virtuously?' Incorporating ethics and aesthetics, this is ***the*** question of well-being. Indeed friends of mine, Helen Mayer Harrison and Newton Harrison are currently working a project called GREENHOUSE BRITAIN that asks, 'as the waters rise gracefully, will we withdraw with equal grace?' One meaning of the word graceful is 'becomingness'.

How will I and those I love survive the accelerating effects of climate change

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'Embodied mind, wellbeing, art and environment' How big is the body?

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There has been an important transition in cognitive science. A mechanistic metaphor that had dominated the subject for the last half century or so has been displaced by a more organic, naturalistic view. The origins of this metaphor can be traced back to the worldview that formed and then dominated the late nineteenth century in Europe. The success of science in explaining the nature of the physical and biological worlds was so remarkable that it seemed possible that a purely physical account of the mental world would shortly follow. It is important to note in passing here that the discoveries of the twentieth century, especially in quantum mechanics, non-linear thermodynamics and in biology, have combined to show how such an account cannot be found. The very stuff of the universe, matter itself, now appears to have a natural tendency organize into complex systems (e.g. Gregersen, 2003). The interrelations found in plants and animals no longer need some special explanation - the cosmos itself is organic.

The mechanistic metaphor, having served a useful purpose, which was in part to discipline our investigations and in part to give psychology the status of the natural sciences, has moved down the research programme, displaced by approaches which stress the enactive, embodied nature of mind. Information processing models retain their place but within a widening armoury of concepts, techniques, views and practices that make up a post-modern, pluralist discipline (Gergen, 2001).

This is welcome news, since we are diminished if psychology merely offers us a mechanistic account of the mind which is inherently reductive and marginalises experience. We need a discipline that deals with the encounter between mind and the world and that provides us with an account of experience that we can recognise. The turn to embodied theories of cognition along with the rehabilitation of subjective data go some way to doing this.

There are implications here for what we think of wellbeing and how we study it. A big part of good health and wellbeing is to feel at ease and with the natural world around us. Despite the urbanised lifestyles of most human beings, the built environment is not experienced as natural. The natural world is the living world of animals, plants, growth and seasons. Wellbeing will diminish if we feel alienated from this natural context by a theory of mental life that reduces it to mere mechanistic rules and representations. We would then feel ourselves to be mechanistic intruders in an organic world and our experiences would in some alienating sense remain outside nature.

Psychologists look within, to the activity of the brain, to explain how we come to have the experiences we do. This direction has dominated psychology for

decades, in the shape of behaviourism and more recently in the form of cognitive neuroscience. Other psychologists look without, to the social matrix within which the mind develops. The embodied approach balances both these directions. It traces the natural history of the mind by looking into the biological and cultural evolution of our cognitive skills.

Merlin Donald (1991, 2001) provides a framework for the cultural origins of mental life. He distinguishes two major transitions separating three broad stages. The first is the Mimetic stage, in which proto humans learned to communicate ideas and organise collective action by imitation. This stage, beginning roughly two million years ago saw the emergence of language and, more arguably, of symbolic thought. The second stage beginning about one hundred and fifty thousand years ago, Deacon calls the Mythic stage, since it saw the beginnings of human attempts to understand personal existence and the origin of the natural world through supernatural stories. As the modern mind emerged with the rise of what we would now recognise as the scientific rational approach, we enter what Donald calls the Theoretic stage, beginning about two thousand years ago.

Accepting this framework, or something like it, we have also to accept that the origins of human mental life must have been deeply embedded in our embodied interactions with the natural world. How we think about the natural world, whether in our immediate activities or in our more abstracted speculations must, eventually, be grounded in what the world presents to organisms with our type of bodies and our capacities for action.

Now this recognition of embodiment as the mind's foundation has been the major feature of the turn away from the machine metaphor of the past couple of decades. This turn is not just significant for psychology but has wider implications for how Western cultures think of the world and the place of human being in it, as Lackoff and Johnson make clear (Lackoff and Johnson, 1999). Instead of a world of immutable Platonic Ideals and laws we find a dynamic, evolving world of interaction and change. The workings of human mind in this view are not some idealised set of rules and abstractions but rather emergent properties of a system within which human beings encounter a world that is partly natural and partly shaped by those actions.

Merleau-Ponty's phenomenological account of perception captures this condition very well (Merleau-Ponty, 1962). He shows how perception depends on action and how the body, since it is both the subject and the object of perception, stands at a unique nexus within the world. In his later writings, he expanded this point into a process ontology which owed much to Whitehead (Merleau-Ponty, 1995). Abram too, finds in Merleau-Ponty the basis for a new and more inclusive picture of the natural world and the place of the human mind in it (Abram, 1997).

There are important implications for wellbeing here. The turn to embodiment provides us with an image of mental life that is less alienating than hitherto and which allows us to become more aware of the interdependence of mind and world. The body becomes bigger as we become more able to see that the boundaries of human mental life and of the sphere of human action must be

set wider than they presently are. While in the short term this may be disconcerting and may lead to feelings of disorientation, in the longer term, it will contribute to making the changes to the way we live that the present ecological crisis indicates are so necessary.

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Gender identity deconstruction or androgyny: Bem Sex Role Inventory (BSRI) revisited.

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Introduction

As far as we can think of, the history of humanity has been written with *androcentric* inks since olden times. Excluding certain periods mainly full of mythological literature or romanticist pose, the domination of men over women is a constant materialised reality that has served as a structural principle for individual gender identities, being this the heritage base of horizontal and vertical segregation of the labour market (Engels, 1973; Delphi, 1977; Scott, 1990; Blackburn, Browne, Brooks & Jarman, 2002). However the logic of this principle is nowadays weaken as social and economical demands of globalisation are calling for new ways of individual adaptation. Therefore, *sex-gender system* and *gender roles* are being conditioned to new features of contemporary employment and labour market different from those which helped G. Rubin in the mid 70s to define such constructs (Rubin, 1975). Since the emergence of computers in working settings and domestic environments along the twentieth Century we have witnessed profound changes in old industrial settings that have altered the composition of the labour force and consequently the whole nature of work and family spheres (Kanter, 1977; Peiro, Prieto & Roe, 1996; Orrange, 2003; Castells, 2004). These technologies have enable people to be in constant, fast communication and contribute to closer relationships of work and family domains thus forcing sex roles to be frequently exchanged and altered. The new social reality is also influenced by *knowledge economy era* whose impact on employees should be better acknowledged for the de-construction processes of work and family spheres. New demands show work-family interchanges embedded in the globalization economy philosophy that have nothing to do with past times and are forcing people to negotiate new power positions and societal roles. However, the consolidation of *neo-capitalism model* in the knowledge society still considers "work" as the economically rewarded activity being made under contractual conditions and therefore empowering those citizens that occupied public positions, normally men. This conception was even explained through *naturalistic* and *essentialist* thoughts by many authors (e.g. Sack, 1975; Ortner, 1974; Rosaldo, 1974) but also was attacked by feminist movements that claimed for sex equity. One of the most important achievements of feminists is certainly the progressive women entry into the labour market that was somehow permitted as male workforce decreased due to many casualties from Big World Wars together with ongoing dying birth rates. Individuals, organizations, and social institutions are taking into account non-work variables and dimensions that might influence organizational behaviours and experiences (Honeycutt & Rosern, 1997). Family and work members have got to attend complex and various tasks and to negotiate new forms of

responsibility distribution. We need to forget old gender dichotomy and encourage masculine and feminine behaviour expectancies. In this sense, the *androgynous role* is an ideal cultural frame to the new encounter. The main objective of this paper is to throw some light on the definition and measurement of androgyny and androgynous roles.

Merging spheres: Masculinisation and feminization processes

Work-family dichotomies historically inherited and reinforced during Industrial Revolution can not be then assumed any more because the impact of new technologies contributes to merge both spheres. We can identify at least two merging processes that separately affect family and work systems named masculinisation and feminization processes, respectively.

Masculinisation processes deal with the progressive fact by which family and private environments are (firstly) demanding and/or (secondly) showing behaviours, skills, expectations, and attitudes traditionally linked to men. It can be admitted that nowadays families have got to face challenging demands that once characterised workplace by means of stress, high standards of work, and complex decisions and negotiations (Hochschild, 1989). Although it is a brand new process at a lower pace, contemporary families face life with new duties related to formal strategies and masculine skills. Formal processes may refer to family competitiveness (e.g. time and efforts devoted when schooling children or soliciting a bank loan), (in)formal education not given at schools, function delegation to institutions such as early nursery (a type of *family outsourcing*?), while masculine skills can refer to self-esteem, leadership, problem solving and decision making, and power motivation at home. Family effectiveness due to rationalization can be achieved by outsourcing strategies, role flexibility and interchange, and allowing independence among its members. There is an old philosophy in British society and similar countries related to masculinisation processes at home named by the motto "*Do it yourself*" (DIY) that reflects the idea of saving money by devoting time and effort at home. DIY is a "defensive production" of nowadays families due to a need to save money and the reluctance attitudes of the few remaining menial workers to attend low income tasks (Comas D'Argemir, 1995). However, to attend this form of work we need to learn to be self-confident and self-manager.

On the other hand, we define *feminization processes* to the progressive fact by which working and public environments are (firstly) demanding and/or (secondly) showing behaviours, skills, expectations, and attitudes traditionally linked to women. While *feminine attributes* deal with emotions and familiar, informal relationships, *masculine attributes* are link to rationality and formalization. Through feminine processes employers are demanding attributes and qualities traditionally associated to women such us communication skills, loyalty, team work, delegation, personal attendance, commitment, sensitiveness, in an attempt to look for "soft" solutions to present problems (Apostal & Helland ,1993). In this sense, organizations gain effectiveness by using semi-autonomous groups of work, stimulating creativity, allowing delegation and empowerment, being flexible and communicative. From the view of Occidental organizations, new environmental conditions characterised by complex multi-ethnically composed workforce encourage us to bear in mind qualitative and affective factors in human resources management such us culture, diversity,

communication skills, or team-work (Gutek, Repetti & Silver, 1988; Goodstein, 1994). The fast track that surrounds nowadays businesses can not be tackled by old procedures that understood organizations as rational, organised, and stable realities. In stead, a kind of "irrational" thinking should be considered as organizations must be seen as chaotic realities design by powerful groups with political interests. For this *science of the artificial* (Silverman, 1971; Simon, 1995) important enquires of modern organisations refer to different forms of creativity, action-research, innovation, effective negotiation, organizational health and development, conflict resolution, blended learning, and so on (Gutek, Searle & Klepa, 1991). Nevertheless, contemporary studies have proved that work and working environment are still portrayed and perceived as "battle fields", dangerous world in which to act without feelings, highly rational, and individualistically (Infante & Marin, 2005).

Merging gender: Androgynous role or the discredit of gender

As work and family institutions seem to merge by the progressive development of new information technology the more the pressure individuals feel to exchange duties and roles in a more flexible way. Since the 70s, the continuing rate gains of labour force participation for women are certainly modifying the traditional division of gender roles. Although the obtained figures on roles exchanges among sexes are more a wish than a real fact, we do witness more sharing activities between men and women. Because work field is a universal source that (economically) supplies others human fields, women are more enforce to tackle both work and family roles than men due to life sustainability and social image, respectively. We need to be skilful to manage multiple roles independently or through constant negotiations between parts. For that purpose, it seems to be useful for any male or female worker to act using gender roles when needed that is, being androgynous. *Androgynous role* is said to be the most efficient way of adaptation because male and females attributes are used contingently with environment demands inside an enrichment encounter among gender (Woodhill & Samuels, 2004).

Androgyny is an ill-defined concept in a lack of literature field that should be better acknowledged. Androgyny has nothing to do with genital pathology and it refers to a female or male person that is capable of acting and thinking both in terms of male and female gender roles. The androgynous role was first used in Plato's "Banquet" classic book and described a imaginative creature both male and female with four legs and four arms but with a single head. The author talks about the myth of the androgynous in which he describes a curious creature with rounded body shape, four legs and four arms, two-faced, but with only one head. As being a fusion of sexes, androgynous were known as having great power so Zeus order to split them in two complementary parts. This myth may have served as a starting discourse for the popular saying that encourage heterosexual individuals to find in life the exclusive "other half" to whom they should engage for ever. In the psychodynamic theory of Jung (1960) the psyche is said to be composed of a masculine (animus) and feminine (anima) element that can be placed in either the outer personality (persona) or the hidden personality (shadow). As different from men, women were described as placing their animus in their shadow and the anima aligned with the persona, while being the other way round in the case of men. Jung's

theory indicated that good-integrated personalities were seen in those who showed the hidden part of their personality that is, being androgynous. Androgynous role can be defined as the group of behaviours, attitudes or actions that are socially expected in men and women at the same time and used in accordance with the context. Sandra Bem (1974, 1977) was the first to apply this concept to work settings. She described it as a high propensity of both feminine and masculine characteristics in an individual. Androgynous role can be understood as a form of enrichment process between men and women that allows great adaptability using "men" and "women" resources. It refers to a great variety of constructed cultural images of a woman-being-a-man and vice verse (Ramet, 1996).

In summary, I have already proved that complement division of roles between sexes is disappearing as men and women learn to self-govern themselves. We witness new behavioural and attitudes forms among people that might describe a fusion between genders and may be link or not to sex-orientation changes. The gender reduction is reinforced by new forms of gender socializations and social practices such as piercing, unisex clothes, cosmetics, etc. Consequently, modern societies of highly technological countries will not are able to use gender as a structural variable nor to build individual identity. As James (1997) pointed out, psychological differences among men and women tend to evaporate as they both grow up and act similarly. Gender culture and identities will have to be redefined in a way that sex-role, as a socially constructive reality, will not served as a basic principle of discrimination.

Androgyny nature and measure

Androgynous individuals are said to have higher self-esteem than non-androgynous (Lundy & Rosenberg, 1987; Shaw, 1983; Heilbrun, 1981; Flaherty & Dusek, 1980) but following studies have came up with different results. For instance, Whitley (1985) found that masculine role carried greater weight of self-esteem. Using a complex model, Marsh and Byrne (1991) admitted that self-esteem as a whole variable was not associated to any neither sex-typed nor androgynous role but to their specific demands of attributes in a given situation. Overall androgynous role are not totally proved as being advantageous (Cook, 1985).

The most common way to measure androgyny is by using the Bem Sex-Role Inventory (BSRI). Bem (1974) constructed a scale made of 60 items referring to adjectives of the masculine (e.g. ambitious), feminine (e.g. shy), and/or neutral (e.g. helpful) sex-role stereotypes, each of them with 20 items. Every item is scored on its own subscale using a Likert-scale of 7 points which ranged from *"never or almost true"* (=1) to *"always or almost true"* (=7). The confluence of the subscales scores may define an individual as having an androgynous, gender-typed or undifferentiated sex role accordingly to a prefix chart (*see table1*). Androgyny is then a gender identity consisting of a balance of (high marked) feminine and masculine traits. Operationalization of androgynous role and identity is a difficult task as it may culturally vary in relation to social male/females prejudices and stereotypes of a given society.

		Masculine subscale	
		Low	**High**
Feminine subscale	**High**	**FEMININE**	**ANDROGYNOUS**
	Low	**UNDIFFERENTIATED**	**MASCULINE**

Table 1. BSRI classification system of an individual within its subscales scores.

Notwithstanding, if we consider androgynous role as a "perfect mix" of two physically and mentally complementary individuals, adopting or not an androgynous role would depend upon eliminating (or minimizing) those negative traits of the other gender while adopting positive ones. In the gender identities and stereotypes desirable and undesirable traits can be found and so can be named distinctive traits to define positive and negative androgyny. In BSRI's measure negative and positive traits are added and in doing so *false* (better to say, *negative*) androgynous roles can be obtained and may others remain unrevealed. For instance, a hypothetical androgynous woman could appear as cheerful (positive feminine trait) and, at the same time be aggressive (negative masculine trait). In this sense androgyny should be described as a composition of positive male a females features that complete a human being contrary to gender-typed roles and identities that tend to be dysfunctional, inhibiting, and imprisoning. Sharing Woodhill and Samuels (2004) proposal, we can better describe an androgynous person as having positive traits of both feminine and masculine ones while eliminating (or minimising) negative ones. Again, a female manager that shows great leadership ability and acts aggressively could be described as having a negative androgyny identity. We found this distinction very needed as most of our latest studies indicate that successful working women imitates men in their bad attitudes and behaviours and in doing so supporting male dysfunctional (work-family) discourses (Infante & Marin, 2005; Infante & Matos, 2004). In summary, to be positively androgyny we need to get rid of negative traits of ones gender (positive lost) and gain positive traits of others gender (positive gain) in what should be called a *role integration*. Following these arguments, *table 2* depicts the give-and-take game between gender-roles in order to properly define androgynous role and androgyny identity.

	OTHER GENDER		
SELF GENDER	*Positive gain*	*Negative gain*	*No gain*
Positive lost	(R1) Role ambiguity	(R2) Role devolution	(R3) Role involution
Negative lost	(R4) Role integration (Positive androgyny)	(R5) Role mutation (negative androgyny)	(R6) Role evolution
No lost	(R7) Role evolution	(R8) Role involution	(R9) Gender role

Table 2. Possible type of roles in the give-and-take process of gender traits.

The presented chart admits that both men and women are totally complementary and their best outcomes are guaranteed by integrating feminine and masculine skills into only one and being aware of the disadvantage of using gender-typed roles. The definitions of the encounter roles are as follows:

(R1) Role ambiguity: occurs when an individual shows or executes other's gender role but loosing his/her own effective expectancies in a given situation. For instance, a woman may be risky (other's positive trait) in a negotiation but constantly refuses to show the (expected) empathy or understanding (one's positive trait).

(R2) Role devolution: describes forms of behaviour expectancies in which an individual "inherit" the best of other's roles at a higher personal price. For instance, a woman that tries to perform a leader role by being too competitive (other's negative trait) and not showing feelings of understanding (one's positive trait).

(R3/R8) Role involution: due to unlucky creativity towards uncertainty, these situations describe bad learning or adaptation to modern times. For example, a man that loses his braveness (one's positive trait) or a woman who refuses to be affectionate (one's positive trait).

(R4) Role integration (positive androgyny): the best case that we can think of an androgynous role is when an individual uses both gender expectancies in accordance with the situation. For instance, when a father is being tender (other's positive trait) with his children and avoid violence (one's negative trait) to solve problems, or when a mother shows both concern with the health of her child (one's positive trait) but avoiding flatterable attitudes towards him (other's positive trait).

(R5) Role mutation (negative androgyny): occurs when ineffective expectancies of one's gender are replaced by other's ineffective ones in an attempt to achieve power positions as socially prescripted. For instance, when a woman, in a wish to *freely* attend her natural needs normally denied by society (one's negative trait), shows dirty habits (other's negative trait) allowing her to burp or scratch impolitely. These roles are commonly seen on top managerial women that even imitate men in their appearance (short or untidy hair, trousers, lack of complements, dark colours, light make-ups, etc.).

(R6/R7) Role evolution: individuals may drive themselves towards positive enhancement by just learning other's positive traits such as communication skills (men) or decision-making techniques (women) but with no other significant role expectancies exchange.

(R9) Gender role: when no changes at all are being portrayed we then can talk about traditional gender roles, male and female gender roles.

The incident rate of androgynous roles among contemporary citizens might be lower than those obtained by Bem (1977). Recent investigations on the appearance of androgynous role in Spanish television programmes (Infante & Marin, 2005; Infante & Matos, 2004) have observed that working women are significantly more likely to be criticised when adopting male roles and are

described as being rude and less attractive than when they are commitment to female gender-roles. Alternatively, men are discouraged to adopt female roles by being described as homosexuals or by losing their sexual power or strength. The traditional gender dichotomy is still conditioning work, market, and economy activities (*see* Osca & López-Sáez, 1994) and should be erased by redefining men and women with androgynous features. Consequently, men and women need to learn how to adapt themselves to new historically different domains in which success may depend on gathering other gender's positive knowledge and abilities.

Method

Sample

A sample of 126 Spanish workers enrolled in a postgraduate research course on Criminology and Labour Relations took part in the present study. Ages varied from 23 to 43 year old with a mean of 27.4 (Std= 2.32) being 43.7% male and 56.3% female.

Procedure

The students were asked to anonymously complete the BSRI for self-descriptions and afterwards to discuss about two selected pictures that showed work-family worries. Particularly, they were asked to describe the pictures and think about problems, messages and solutions that might be proposed. *Picture A,* titled *"Wife calling"* (female condition) described a women talking through the phone with her husband and telling him that she was rejected in a job interview when she stated the need to share the job duties with her family life (going to doctor's, school, and so on). *Picture B,* titled *"Bank services"* (male condition) advertised loan facilities of a Spanish bank and showed a man holding his twins on his lap with a surprising face. Both pictures were used to help student to identify with the problem and to express their attitudes and opinions in a group discussion.

Results

Table 3 shows the obtained means in each trait by sex. Mean contrast analyses showed that 48 out of 60 adjectives distinguished between male role (16 adjectives), female role (13) and gender-neutral (19) in the same line as Bem's scale. However, only 27 of them were found to be statistically significant. Apart from the obvious dichotomy masculine-feminine, the best way to describe a man was using the traits *independent* and *athletic* while women tend to use *strong personality* and *truthful* (originally a neutral trait). In allocating the traits there was an 80% of coincidence with original BSRI, 80% in the case of neutral traits (that is, no significant differences among scores), and 95% and 65% for male and female gender roles, respectively. To obtain a shorter version of the BSRI, (non-significant) neutral traits were taken off the scale and traits 25 (*leadership ability*) and 49 (*acts as a leader*) were considered as one due to their close meanings.

Consequently, 26 traits compiled the BSRI reduced version (r-BSRI), 13 for each gender-role, three of which can be easily assumed as negative in each case. For male gender role *aggressive, competitive* and *ambitious* was taken as negative traits as being incompatible with a work-family balance culture of nowadays knowledge economy as seen in the literature revision (although they might suit well in capitalism economy).

	A	M	F	S
1. self reliant	4.88	**5.09**	4.72	4.03*
2. yielding	2.75	2.65	**2.82**	3.25*
3.helpful	5.52	5.45	5.57	
4.defends own beliefs	5.56	**5.69**	5.46	3.23*
5.cheerful	5.91	571	**6.07**	3.01*
6.moody	2.48	2.49	2.47	
7.independent	4.99	**5.18**	4.84	7.21**
8.shy	4.15	4.33	4.00	
9.conscientious	5.76	5.75	5.76	
10. athletic	3.99	**4.69**	3.37	14.6**
11.affectionate	5.62	5.53	**5.69**	5.47*
12.theatrical	2.76	3.15	2.46	
13.assertive	4.74	**5.02**	4.51	3.28*
14.flatterable	4.71	4.38	**4.97**	3.55*
15.happy	5.82	5.53	6.06	
16.strong personality	5.18	5.02	**5.31**	7.78**
17.loyal	6.31	6.22	6.38	
18.unpredictable	3.74	3.44	3.99	
19.forceful	4.65	**4.89**	4.46	2.89*
20.feminine	4.16	1.75	**6.12**	234.8***
21.reliable	5.61	5.40	5.78	
22.analytical	5.24	**5.45**	5.06	3.01*
23.sympathetic	5.76	5.62	**5.88**	2.97*
24.jealous	3.42	3.35	3.49	
25.leadership ability	4.36	**4.55**	4.21	3.78*
26.sensitive to other's needs	5.15	5.22	5.10	
27.truthful	6.11	5.85	**6.32**	9.44**
28.willing to take risks	4.54	4.42	4.63	
29.understanding	6.06	5.89	**6.19**	3.39*
30.secretive	4.80	4.89	4.74	

	A	M	F	S
31.makes decisions easily	4.98	5.13	4.87	3.34*
32.compassionate	5.21	5.31	5.13	
33.sincere	6.06	5.91	6.18	
34.self-sufficient	5.50	5.49	5.50	
35.eager to soothe hurt feelings	4.79	5.16	4.49	
36.conceited	2.24	2.47	2.04	
37.dominant	2.92	2.80	3.01	
38.soft spoken	5.07	5.04	5.09	
39.likable	5.71	5.62	5.78	
40.masculine	3.65	**5.93**	1.81	186.7***
41. warm	5.11	5.25	4.99	
42.solemn	4.25	4.56	4.00	
43.willing to take a stand	5.02	5.05	5.00	
44.tender	4.93	4.65	**5.18**	4.36*
45.friendly	5.94	5.87	6.00	
46.aggressive	2.41	2.49	2.34	2.77*
47.gullible	3.26	3.04	3.54	3.22*
48.inefficient	2.06	2.13	2.00	
49. acts as a leader	3.74	**4.09**	3.46	4.82*
50. childlike	3.12	3.20	3.06	
51. adaptable	5.20	5.13	5.25	
52. individualistic	4.15	4.05	4.22	
53. not harsh language	4.30	4.07	**4.49**	3.13*
54. unsystematic	3.52	3.67	3.40	
55. competitive	4.81	**5.11**	4.57	4.05*
56. loves children	5.63	5.60	5.66	
57. tactful	5.39	5.64	5.19	
58. ambitious	4.61	**4.82**	4.44	4.25*
59. gentle	5.97	5.80	**6.10**	3.70*
60. conventional	4.44	4.51	4.38	

Table 3. Obtained BSRI´s means, standard deviations, and mean contrasts for gender. Neutral traits in *cursive*, selected traits and higher means in **bold**; Keys: A=average, M= males, F= females, S=significance (* p=.05, ** p=.01, *** p=.001).

For female gender role, *yielding, flatterable* and *gullible* were considered as negative traits because they support the past passive role of women. *Truthful* was included in the female gender role as it proved to be highly significant for self-description. Reliability tests were conducted to check item's consistency and significant alpha scores of .81 and .73 were obtained for BSRI original (n=60 items) and new version (26) scales, respectively.

Once the new scale was defined, descriptive analyses were obtained for both former and new scales (*Table 4*). Surprisingly, mean scores on undeciderable (negative) traits were higher than those obtained on deciderable ones for both gender roles. As it was expected, male role scores were the same in both scales but significant differences were found for female role.

	r-BSRI						BSRI		
	items	**Min.**	**Max.**	**P80**	**Std**	**Mean**	**mean**	**Std**	**Z**
Male-role	13	2.85	6.46	5.32	.81	**4.52**	**4.49**	.72	-1.44
Desiderable (D)	10	1.41	2.67	1.18	.82	1.28			
Undesiderable (U)	3	1.00	7.00	5.00	1.10	3.94			
U-D	13			4.64	.76	3.36			
Female-role	13	3.31	6.23	5.53	.69	**4.97**	**4.89**	.60	-2.85**
Desiderable (D)	10	1.85	3.76	2.12	.86	2.00			
Undesiderable (U)	3	1.33	6.33	4.66	1.12	3.57			
U-D	13			3.75	1.88	2.16			

Table 4. Descriptive analyses for both former (BSRI) and new (r-BSRI) scales.

Calculations for androgyny cases were obtained in both scales. Percentile 80 was the criteria to discriminate in each dimension (male and female) between high and low scores. In the r-BSRI, the criterion was applied after subtracting positive to negative traits scores in each dimension in order to obtain "real" positive androgynous identities. *Table 5* shows results on this attempt. Quantitatively speaking, the new version proved to be accurate in distinguishing among sex roles. Even more, the r-BSRI obtained further more androgyny cases and almost the same incidence on gender-typed and undifferentiated sex role identities.

	r-BSRI			BSRI		
	Male	**Female**	**Total**	**Male**	**Female**	**total**
Undifferentiate	65.5	66.2	**65.9**	69.1	59.2	**64.1**
Gender-typed	30.9	26.8	**28.6**	27.3	36.6	**31.9**
Androgyny	3.6	7	**5.6**	3.6	4.2	**3.9**

Table 5. Distribution of roles for both sex-role scales.

In order to contract predictability of the scales, androgynous student's comments on the prompting material (pictures A and B) were also analysed. Only 16 students were classified as androgynous, 7 using the r-BSRI and 9 from the BSRI with only one coincident case. In the first case, the average age was 30.7, 57% being females and 43% males. The average qualification of this group was 6.75 (10-point scale). This group showed positive attitudes towards balancing both work and family demands. Their comments on the pictures clearly stated the work-family problem as being shared by both sexes supporting the idea of sharing duties and describing work-family conflict in terms of time-related (*Table 6*). Finally, it is significant to mention that all of them described picture A as "a sat man holding *his* twins" while the majority of the sample doubted to make this adscription.

On the other hand, the androgyny group obtain by the original BSRI was younger (25.8 mean age), mid male and female, and highly family centrality. Overall qualifications at present academic year summed up to 5.52 (10 point scale). Comments of this group clearly slant to traditional believes on work-

family matters with a tendency to allocate men in work sphere even if they had described the problem as shared among sexes. Discourses among them were primarily economic and linked to time related work-family conflicts. Some of their solving suggestions included job adaptation to women rather than sharing duties.

Androgyny cases comments obtained by the BSRI

- ***"they (men) believe that their work is not enough" F-PA***
- ***"in order to live comfortable and maintain a home he should work outside and both should help in house duties" M-PA***
- ***They (men) don't reserve time for their children" M-PA***
- ***"nowadays it is the father's salary that maintains house and then work harder outside home" M-PA***
- ***"...she has impose her conditions and the organization has a right to hire or not" M-PA***
- ***"the father would have to work harder than the mother as she is to attend the kids much longer" F-PB***
- ***"I can see a man with two children probably his children" M-PB***
- ***"the surprise (having twins) is bigger to the mother, wrong chosen photo" F-PB***
- ***"(men) have to economically support the family in greater amount than mothers" F-PB***

Androgyny cases comments obtained by the r-BSRI

- ***"men and women need external support to handle work-family duties" F-PA***
- ***"Both (parent) should be aware of their duties at rearing the twins and gaining money" M-PA***
- ***"It is a man holding his twins" F-PB***
- ***"...she didn't really want to obtain the job" M-PB***
- ***"...domestic duties should be shared" M-PB***
- ***"men do not have time to spend at home" F-PB***

Non-androgynous comments obtained in both scales

- ***"(men) don't know how to take care of children..." F-P1***
- ***"in general they (men) are not made for home duties" F-C1***
- ***"They (men) feel worried being at home" F-C1***
- ***"men don't have the burden of child rearing" F-C2***
- ***"a father is not going to risk his job for a nonsense" F-C2***
- ***"women are a cost for organizations" M-C2***
- ***"women are unskilled to work and are better prepared to attend homes" M-C2***

Notes: F= female student, M=male student; PA=Picture A (*"wife calling"*), PB=Picture B (*"bank services"*).

Table 6. Repeated comments from androgynous and non-androgynous students at the scales.

However, androgynous comments in general were clearly away from old concepts and quotes on these issues. They were not anchored anymore on naturalistic theories that place men and women in separate roles due to natural skills and define individual work-family duties regardless sex. As a curious detail, 75% of men and 61.1% of female non-androgynous identity

students would not describe the twins as belonging to the pictured man (Picture B) and nearly 20% of the rest were doubtful. Even more, Picture B, which portrayed a work-family conflict of a male, appeared to incite higher debate among students than Picture A as it was perceived as targeted to men by the 86.2% of the sample.

Conclusions

I have used BSRI to classify a student sample on their androgyny identity and gender roles. More over, there was an initial attempt to create a shorter (updated) version of the scale and to define a more precise calculation of androgyny measurement. A sample of 126 Spanish students completed the BSRI scale and took part on focus groups on work-family issues. The final r-BSRI was formed of 26 traits, 13 referring to male and 13 referring to female traits, three of which were defined negative in each group as being incompatible with contemporary economy. Therefore, male gender role can be defined as *self-reliant, leadership ability, defends own beliefs, makes decisions easily, independent, athletic, masculine, assertive, forceful, analytical* (positive), and *aggressive, competitive,* and *ambitious* (negative). On the other hand, female gender role is portrayed as being *sympathetic, truthful, understanding, cheerful, affectionate, tender, strong personality, not using harsh language, gentle, feminine* (positive) and *yielding, flatterable,* and *gullible* (negative). Surprisingly, average scores for negative traits were significantly higher than positive ones maybe in a wish of the respondents to fulfil social images of gender. I have tried to redefine androgyny as a complementary gain among gender-typed roles in a "give and take" process among men and women due to work-family merging. The gender role distribution among the scales -original and shorten version- were similar although different and more androgyny cases were found using the r-BSRI. However, there was only one coincident case among them when detecting androgynous identities. In all selected cases, useful comments to balance work-family duties among both men and women away from naturalistic theories were successfully made and so proving the validity of the scales. Particularly and coincident with the literature, r-BSRI androgynous group was primary female, older, work-family centrality identity and showed higher academic results. On the contrary, androgynous cases using BSRI original scale grouped nine younger students, half female, with family centrality and lower academic scores. Relative to the original scale, comments of the r-BSRI androgynous group were more neutral balanced, with better picture description of share duties and away from economical and political discourses on work-family interface (and so stating the social changes on individuals rather than external agents).

In summary, there is evidence to encourage future research on the concept of androgyny that may throw some light on balancing incompatible tasks and uncertainty among contemporary citizens. Some data has confirmed that the BSRI scale should be updated and the obtained shorten version have proved to be useful in better detecting androgynous identities. But obtaining plausible measurements must not be enough. Further studies should also provide more explanations on how to define androgyny in real practice and to engage people in group discussions to share and negotiate new neutral-gendered roles that may suit contemporary constrains of the present Century.

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Joy at work: the impact of non-professional singing workshops on employee wellbeing

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Final singing session during RIHSC conference

Introduction

There is limited evidence for the link between singing and wellbeing, although the impact of music on mood is well documented. Stacy, Brittain and Kerr (2002) explored the issues underpinning the links between singing and health. They draw attention to the evidence stemming from the 1940's on the health benefits of singing, ranging from enhanced respiratory functioning (and reduced asthma and other bronchial disorders and improvements in consumptive conditions), release of endorphins, improved posture and enhanced mood.

There is less evidence of self-reported benefits to general wellbeing (Grape , Sandgren , Hansson , Ericson , and Theorell , 2003) and stress in the workplace. In this context, choirs have received some attention. Carter (1954) documents workplace choral activity from 1935. Clift and Hancox (2001) explore in some detail the perceived benefits of singing to members of a University college choral society. They frame the work within discussion of wider debates about arts for health and in particular music for health, arguing that "of all the arts music may justly claim to have the greatest significance to health and healing" (p. 249). They examined the impact of participating in the choir on perceived physical, emotional, social and spiritual dimensions of wellbeing.

Clift and Hancox point to the claims made by Voices Foundation, which promotes the place of singing in education, to singing as a benefit to posture, the lifting of mood, relieving stress, encouraging the release of pain relieving endorphins, improving circulation, boosting the immune system and exercising respiratory muscles. Whilst there is no literature on singing in the workplace as a vehicle for managing stress, if it does indeed have the impacts summarised above, it should be a useful method of stress management.

The studies addressed above talk of choral activities and formal singing activity, which often require ability and prowess. There is nothing in the literature that looks at singing for adults, in the workplace, that is inclusive and not performance related.

Wellbeing

By wellbeing, we mean more than satisfaction with life, and satisfaction with physical, emotional, social and spiritual gains. Shah and Peck (2005:2) remind us:

> .. *people also want to be leading rich and fulfilling lives - developing their capabilities and fulfilling their potential.*

They propose two dimensions of personal well-being:

- peoples satisfaction with their lives, which is generally measured by indicators which capture satisfaction, pleasure and enjoyment;
- people's personal development, which includes being engaged in life, curiosity, 'flow', personal development and growth, autonomy, fulfilling potential, having a purpose in life and feeling that life has meaning. For people to lead truly flourishing lives they need to feel they are personally satisfied and developing.

For Shah and Peck, then , eudemonic wellbeing (personal development and fulfilment) is as important as hedonic wellbeing (satisfaction and happiness).

This project sought to evaluate a pilot inclusive, workplace singing workshop in a University, and examine its impact on reported wellbeing. The project had a number of aims:

1. To examine the impact of workplace singing workshops on reported wellbeing;
2. To assess the different impact of different kinds of singing on reported wellbeing in the workplace;
3. To examine differences in reported wellbeing in terms of previous experience as singers, occupation, age (depending on size of group participating);
4. To identify the most effective means of evaluating the wellbeing impact of participation in signing workshops in the workplace.

Design and Method

The study was a pilot project, collecting preliminary data about the reported experiences of participating in a singing workshop in the workplace. Initially it had been intended to undertake a quasi-experimental (pre, post and follow up) design, with questionnaire data to assess the impact of participation in singing workshops on reported wellbeing was used. In practice the study remained a qualitative study albeit with information collected at different time points (initial, phase, midway and final phase and following workshops) and through different means (questionnaire, interview and discussion).

In order to enable comparisons to be made with other singing processes in Universities, it had been intended to use the same questionnaire assessing wellbeing as used in a previous study (Clift and Hancox,, 2001). However, permission had not been gained in time. Instead, the categories used by Clift and Hancock were inserted into a brief pre-workshop questionnaire for participants. Data were collected at first workshop, at the end of the workshops. In addition, participants were asked to evaluate briefly the first, second and fifth singing session. Once the 10 workshops had been completed some of the participants were approached for more in-depth, albeit brief, interviews, and a group interview/discussion was organised, in order to explore reported change in both hedonic and eudemonic wellbeing.

Data were be analysed, through the use of descriptive statistics and thematic analysis in order to identify the overall impact of singing sessions on reported wellbeing; to assess differential impact of the different sessions on reported wellbeing; examine any differences between those who see themselves as singers and those who do not, in terms of reported wellbeing.

Ethical approval for the project was gained from the Faculty Ethics Committee.

A ten week programme of singing workshops, facilitated by an experienced community singing tutor was provided on one of the University campuses and an open invitation issued to all staff via the whole-staff email. On the site of the workshops, notices were posted opening the singing workshops to all students and staff. No previous experience of singing was required. The final session was held in a public space during the course of the RIHSC conference. All participants were informed that the sessions were part of a research project and signed consent was obtained (See Appendix 1).

Participants

The first workshop attracted 21 participants. These included academic staff drawn from 6 of the 7 campuses of the University, students, staff from central divisions (such as finance, educational liaison). Some of these participants did not attend subsequent sessions due to logistical/organisational problems rather than an unwillingness to continue the sessions.

19 attended the second session. Over the course of the 10 sessions, numbers changed due to a variety of factors: holidays, examination invigilation, meetings etc. A core group of 10 singers attended on a regular basis, consisting of academic and support staff from different campuses. One session was reduced to 4 singers.

Preliminary Results

Pre-workshop questionnaire

16 participants completed the pre-workshop questionnaire. Of these, 10 defined themselves as non-singers, 4 as singers, with 2 considering themselves to be able to sing "a bit" (one stated that s/he was unable to hold pitch).

Reasons for attending the workshop

The most frequent reasons given for attending the singing workshops related to singing: singing in and of itself as a source of enjoyment, singing collectively, opportunity to sing or singing in a non-judgemental environment, exploring ability to sing/singing with others. Others reasons were linked to perceived benefits of singing, such as relaxation, confidence building, joy, health and well-being. One respondent noted skill development: raising technical awareness of the physiological aspects of singing, such as a motivational factor. Other motivations extending beyond the joy of singing to wider benefits such as the opportunity to meet colleagues in a non-work context, team-building, valuing others and supporting RISHC activities.

Expected benefits

Physical benefits: Better breathing (five respondents) and better posture (three respondents) were cited as expected physical benefits, as well as relaxation (three respondents). Two respondents expected to benefit from improved lung function. Positive impact on the voice was noted by a number of respondents, voice projection (one respondent), voice improvement (two respondents), voice awareness (one respondent). Other expected benefits were: awareness of diaphragm and ability to sing.

Emotional benefits: Relaxation and related terms were frequently cited: calming (four respondents) and distressing/relaxation (four respondents). Happiness (four respondents) and feeling good (three respondents), including feeling good about oneself, were also frequently cited. One respondent expected some kind of spiritual uplift, thus seeing emotional and spiritual aspects as linked. Singing was seen as a good emotional outlet by another respondent, whilst for another the workshop was expected to improve emotional well-being.

Social benefits: The main expected social benefit was meeting people at work, a rare opportunity for some. Three respondents referred to the opportunity to do something enjoyable and social with colleagues. For another the opportunity to establish a very different kind of communality with others in the workplace was important. Allowing colleagues to connect (one respondent), and appreciating skills of colleagues otherwise not recognised (one respondent) were also mentioned, as was the expected confidence gained by performing collectively or in a community, (one respondent) and team building (one respondent).

Spiritual benefit: A significant number of respondents did not consider this to be relevant (four not applicable, three non-responses). Others (two respondents) expected some form of spiritual benefit but were unable to articulate what this might be. The collective dimension of the singing was cited by one as a potential spiritual benefit, going beyond the individual self to a sense of connection to the whole. An expected relaxing, calm and therapeutic experience was perceived to be of spiritual benefit, as was Feeling at peace and better karma or chakra.

Skill development: Most skills expected were related to improved singing (twelve respondents), overwhelmingly general singing improvement, but also more specific skills such as pitch control, harmonising and voice awareness. Transferable skills expected were better listening and auditory memory development, better breathing, lecturing skills and team work.

Other: A small number of participants cited other benefits: sense of well-being, new friendships, managing large groups in artistic contexts, improving work concentration in period following singing workshop and testing longer term benefits for working climate (each from one respondent).

It should be noted that this questionnaire was completed after the first workshop. Therefore responses to expectations would have been influenced by the experience of the first session.

Reported Experience of the sessions

Initial reported experiences

The first post-workshop questionnaire was distributed at the same time as the pre-workshop questionnaire. 12 participants completed the questionnaire.

Participants were asked about the three things they liked most about the session. Seven participants noted the quality of the facilitator, her warm, welcoming manner as well as her expertise in singing technique, and her "gentle facilitation". Mirroring the expectations responses, having the opportunity to sing was a frequent response, and one which was related to the enabling atmosphere of the workshop, allowing participants to feel able to sing in an "effortless" way. Eight respondents emphasised different aspects of the way the workshop environment that facilitated singing: atmosphere featured as an important factor in the enjoyment of the workshop, being "informal", "light and easy", "relaxed". Other participants noted the "friendly",

"welcoming" and "inclusive" nature of the workshop. One participant referred to the large size of the group creating an "un-intimidating" environment, whilst another referred to the "lack of pressure'.

Other responses focused on the positive experience of singing. One enjoyed the harmonies, another enjoyed the sound the group made, another the "climatic production of song". Two other participants found the whole experience "fun". Seeing colleagues in another activity and the break accorded by the workshop were also mentioned.

All participants who responded to this questionnaire would willingly recommend the workshop to others. Many of the reasons given mirror those above, and some participants took the opportunity to expand on their three positive aspects already provided, using more compelling terms in which to "sell" the workshop. For example, one participant referred to the "life enhancing experience" of the workshop. Other terms used were "cathartic", "powerful", "self-confidence building" – all very strong ways of asserting the positive role the workshops could play, beyond the mere pleasure of singing. One participant noted the "enrichment of aspects of ones being not used/acknowledge/valued" in work roles". Another noted how the workshop "made me smile all afternoon".

Other more general sentiments of positive well-being were cited: "feeling good", "pleasure", "enjoyable" and fun (cited seven times), as were references to stress alleviation and relaxation. The inclusivity and accessibility of the group were positive reasons for recommendation for two participants, whilst another referred to the workshop being "comfortable".

Meeting new people and meeting them in a less work-oriented context was mentioned by two participants, whilst another cited the balance in a working day as a positive reason for participating. Another participant noted the beautiful music.

Five of the respondents could see no room for improvement in the workshop. Some of the factors which could have improved the experience for others related to the organisation of the workshop: room too small, no song sheet to take away, late arrival of some participants. Others factor related to the content of the workshop: too many religious songs, not enough singing, the need to have greater used of hand gesture to indicate note sequences.

Reported experience after second session

The second evaluation questionnaire was distributed at the second session, one week after the first brief evaluation questionnaire. The questions were the same. 10 participants completed the questionnaire

The responses to the three things most liked about the session were very similar to the responses given in the first brief questionnaire. Again the facilitator was an important factor for most of the participants who responded; eight favourably noted the characteristics of the facilitator as a positive factor in the sessions using terms such as warmth, generosity, welcoming, enabling, engaging, and relaxing. The teaching approach employed by the facilitator was also positively assessed.

Having an opportunity to sing or singing was again referred to by most of the respondents, with one of these being able to sing despite hay fever. The sound made by the group was cited by six ten respondents, whilst one participant liked the collective effort of the group to sing. Four respondents referred to the atmosphere of the groups (warm, lovely, relaxed, or generally good)

The pedagogical aspects of the workshops was given prominence in the responses to this questionnaire, suggesting an increased awareness of technique; teaching approach, learning to sing, learning the technique that enabled efficient harmonising, the progress made from the previous week's workshop, learning a new song, and the ability to retain a song from the previous week.

Other factors mentioned were self-confidence and sense of achievement, meeting new people, de-stressing, distracting time out, good breathing technique.

In terms of improvement, the small size of the room was still a problem, as was the lateness of starting the session. With regards to the room, subsequent sessions were held in Shepherd's House, which was more conducive to singing given the size of rooms, as well as the more pleasing aesthetic aspect. Two respondents noted the lack of time devoted to singing. Another respondent would have liked to have had more people at this session. Four respondents did not see the need for improvement.

Again, all those who responded would be willing to recommend the sessions to others. Three respondents emphasised the way the group enables everyone to sing via its inclusive nature, good facilitation or enabling environment. The impact on well-being was again an important factor due to the workshop being fun and relaxing, being beneficial in "lots of ways", was enjoyable in a collective way, and it made "you feel good". Two participants thought it was a good way to spend a lunch break. Other reasons for recommendation were improved breathing and posture, greater productivity following session and a good tutor.

Reported experience after fifth session (midway)

After the fifth session all participants were emailed in order to gauge how the workshops had improved their well-being. Eight responses were received. Benefits reported were similar to previous responses, relating to both general and more specific aspects of well-being. Three respondents noted the positive impact on their happiness levels derived from singing, another found the sessions to be a mood enhancer. Two participants found it to be a distraction from other problems, with one of these finding difficult to remain angry/annoyed/worried. A lasting sense of enjoyment was experienced by one participant, whilst another found it to be a mood enhancer. One of the singers noted that s/he had rediscovered the joy of singing.
The relaxing/distressing effect was reported by two respondents and three respondents welcomed the time out/break in the working day. The social aspect of singing together (five respondents), including meeting new people, continued to be a factor in the popularity of the workshops.

The facilitator was important for two respondents and learning a new skill for one.

Half of the responses noted areas for improvement: more singing, more people, no religious songs. One was worried that the group was expected to give a public performance (referring to the final session to be held in a public place). These fears were alleviated when it was made clear that it was to be the same workshop format but in a different setting.

Reported experiences at the end of the workshop series

The final questionnaire presented similar questions to the pre-workshop questionnaire, thus providing more information on whether expectations matched the experience of the workshops. However individual expectations and actual experience have not been matched, rather the data presented below is of overall responses. Nine singers responded.

Physical benefits: Some of the physical benefits experienced coincided with those expected, four of the nine respondents found the sessions relaxing (four out of fifteen had expected this), three noted their better posture (four expected this), two noted their better breathing – with one of these noting a lasting effect of this, at least throughout the afternoon following the workshop. Whilst seven had expected better diaphragm awareness, only one respondent experienced this. One participant noted better voice awareness (one expected this). One participant experienced less headaches which s/he perceived to be a result of the workshops, another felt physically "refreshed" and "energised" following the workshop. Another participant felt that frequent singing could perhaps be good for asthma but was unsure whether the workshops had affected this. Another smoked less on Wednesdays.

Improved voice projection was a physical benefit expected by one participant, however this did not figure in the final questionnaire responses, although previous questionnaire responses did refer to more control over volume of voice. One respondent experienced a "freer" voice.

Emotional benefits: From the responses it appears that the benefits expected underestimated the benefits experienced. All experienced markers of well-being such as happiness, joy and enjoyment, and mood enhancement. Three respondents found the workshops generated a feeling of happiness (with one experiencing "childlike contentment"), one participant experienced an uplifting of mood following the session which continued during the week on breaking into song, whilst for another mood enhancement lasted for at least a couple of hours. Another participant found that her eyes "lit up" when talking to friends about the workshop. Other aspects of well-being related to stress relief and relaxation noted by half of the respondents. For one participant the workshop was time out when normally s/he would be working during the lunch-hour. Another noted a positive attitude to work and having something to look forward to.

Sense of achievement and good emotional outlet were expected benefits but did not feature among the responses. However, achievement was one of the themes in previous responses.

Social benefits: Meeting colleagues was one of the main social benefits expected with six out of fifteen participants expecting this to be a social benefit. Seven out of the nine responses to the final questionnaire found this

to be a main social benefit, both in terms of meeting new colleagues and meeting them in a different, nice environment. Establishing a different kind of relationship with colleagues was noted by one participant, something that had been anticipated by two of the participants. Team building was also mentioned as both an expected and experienced benefit, as was the experience of collective singing (each by one participant). One participant noted that s/he had now had the strength to sing as part of her private music-making, which had previously not extended to singing.

Spiritual benefits: Six respondents felt that spiritual benefits did not apply to them. One participant referred to the feeling of integration of body/mind/voice experienced in the sessions. One participant referred to a connection between music and spirituality which was enhanced by the choice of songs.

Skill development: Again a number of skills that participants expected to develop matched those that participants felt had been developed during the course of the workshops. Four of the responses referred to general singing skills (8 out of 15 had expected this). Other participants referred to voice control, auditory control, harmonising, and team work – all of which were referred to in the responses to the pre-workshop questionnaire. Additional skill development experienced by participants were confidence in singing and technical awareness (of difficult aspects of singing).

Other: Negative aspects reported were similar to those reported in previous questionnaires: too many religious songs, lack of time, which hindered interaction and – related to this – bad timekeeping and lack of ownership by group when facilitator was late. On the positive side, two respondents reemphasised the fun experience during the workshop, and the good facilitation. One respondent felt that the workshop illustrated how quickly people who do not know each other can interact in a positive way.

Reported experiences : Post work-shop interviews

Participants were asked to take part in brief interviews at the end of the 10 week workshops to further examine their experience of participation. Two participants agreed to one-to-one interviews. A further group interview/discussion comprising of 5 participants took place. These interviews were overwhelmingly positive, re-emphasising the positive benefits expressed in questionnaire responses. One interviewee talked about how the workshops added a "new dimension" to her life which sustained her personal happiness over the week. This was echoed in the group discussion with one participant referring to the long term effect the workshop had, in that she was happy and had a positive attitude for the rest of the day.

A further, unexpected, dimension which came out of the discussion, was the knock-on effect of positive mood enhancement on others in the workplace (and incidentally in personal life). The workshops also appeared to have the potential of drawing in non-participants when carried out in public spaces, as demonstrated by the workshop which took place in an open space, with people in the vicinity taking part in those songs they recognised.

Few negative points were raised. Not enough singing time had been a frequent comment among the questionnaire responses and was re-emphasised by one

of the interviewees and in the group discussion. Time was an issue for one of the interviewees, whose position demanded set presence at her desk. This kind of logistical problem was also raised in the group discussion as a potential barrier to workplace singing groups.

The religious nature of the songs was a problem for a significant number of the participants. This was expressed both in questionnaire responses and in the discussion group. It was felt that other songs could have been used in order to enhance the inclusivity of the group. On the other hand, at least one of the participants who responded to the questionnaires, was positively enhanced by the spiritual nature of the songs. Inevitably songs that reflect individual values will be experienced more positively. Finding appropriate songs that encompass more universal values may be a way of enhancing the experience for all.

The non-committal nature of the group meant that participants were not always present. This was negatively experienced by some. Too much ebb and flow in participants lessened the coherence. However, others found that this enhanced their experience, participation on a voluntary basis from week to week meant that they dipped in and out when they wanted to. One participant found encouragement from colleagues to attend the workshops during periods of heavy workloads, resulting in a welcomed positive mood enhancement, whilst another would have preferred more commitment, such as working towards a performance, to encourage attendance.

It was noted that making the effort of setting aside one hour a week to attend the lunchtime workshops, even when overloaded with work commitments, could result in an uplifting experience that had a lasting impact during the week, or even physical improvement, for example, for asthmatics. One singer, who was heavily pregnant, reported that her blood pressure remained low during the period over which the workshops took place, in contrast to a history of high blood pressure. Whilst no direct link can be established with any certainty for these positive physical outcomes, it may be that regular singing can lead to positive physical benefits, given the complex and interrelated nature of factors influencing health and well-being.

The group discussion raised the way in which the workshops demystified singing. Through the rapid acquisition of technique, singing became something we could all do, singing was no longer the domain of "other people". Participants were surprised at how quickly they were able to utilise their varying levels of skill to create a pleasing, and performance-quality sound. This was particularly important for those who defined themselves, or had been defined by others, as "non-singers". Such skill acquisition, requiring relatively little investment, had an positive impact on confidence. As a result the positive benefits of the workshop extended beyond immediate physical and emotional effects; confidence, skill identification, leading to personal enhancement were identified.

The individual and group interviewees were asked whether their past experience played a role in how the workshop had an impact on their well-being. Most had had some experience of singing that they had enjoyed. The workshops permitted them to rediscover their singing voice and remind them of the positive aspects of singing. Others had a negative experience of singing

and were now able to find the voice that they were told they did not have. One participant found that the religious nature of the songs evoked a religious past of well-being and spiritual contentment in singing hymns, which she felt uncomfortable with, having broken from that past.

All those asked were eager to continue the experience of collective singing in some form. The group discussion asserted the importance of employee well-being as a justification for workplace support for singing, not only in terms of increased productivity related to distressing and re-energising but also terms of organisational commitment.

Summary of pilot study findings

A number of common themes emerged amongst the reported perceived benefits of participating in the singing workshops: happiness and mood enhancement, de-stressing effect (related to general subjective well-being) collectivity or togetherness, better breathing, perception of improved physical health, confidence and skill acquisition.

The singing workshops hade a positive impact on both eudemonic and hedonic wellbeing (Aim 1).

Detailed impact of different kinds of singing on wellbeing has not been fully understood, but it is clear that some participants had preferences for different kinds of singing which could usefully be explored further (Aim2).

Participants reported positive benefits from the workshops irrespective of their previous experiences of singing, occupation or age. Further exploration of exactly how past experience contributes to specific gains in health and wellbeing is needed (Aim3).

It is premature to make recommendations about the best means of evaluating singing in the workplace. However, the positive results from this qualitative study have shown promise for future work (Aim 4).

This positive feedback will inevitably be related in part to the voluntary nature of participation, and may also reflect a sampling effect – only those with strong feelings may have felt significantly motivated to respond to the questionnaires. Those who participated did so out of a desire to sing and in expectation of positive benefits. However, reported benefits do seem to go beyond those expected by participants, and positive impact on others also seems to be an unexpected by-product of the workshops. The nature of the workshops also seems to be a key factor in producing positive outcomes.

Throughout, the facilitator played a crucial role in creating an unthreatening, inclusive environment which enabled non-singers to discover the joys of singing.

Recommendations

Singing in the workplace proved to be feasible, and an innovation as part of an overall strategy for maintaining the health and wellbeing of people at work.

The pilot study indicated the positive impact of singing in the workplace, in order to maintain occupational health and wellbeing. A strength of the workshops was the extent to which they were open to all. Continuation of the workshops would enable further research into any impact on effectiveness in work. **It is recommended that the workshops continue, open to all, and that research into their impact continues.**

The public place in which the last workshop session took place indicated the potential for reach beyond those actively participating. **It is recommended that future workshops take place in a venue through which non-participants might have contact (such as an entrance hall of a building)**

The evaluation touched upon a phenomenon that has not been noted in previous literature, namely the indirect positive impact on people in the workplace who had not actively taken part in the workshop. **It is recommended that future research examines the indirect impact of singing in the workplace on people not actively participating in the singing.**

Note: this is a draft report: all participants and facilitator of the workshops will have the opportunity to comment upon and contribute to changes in the final version of the report.

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Midwives' Views on Rising Caesarean Rates

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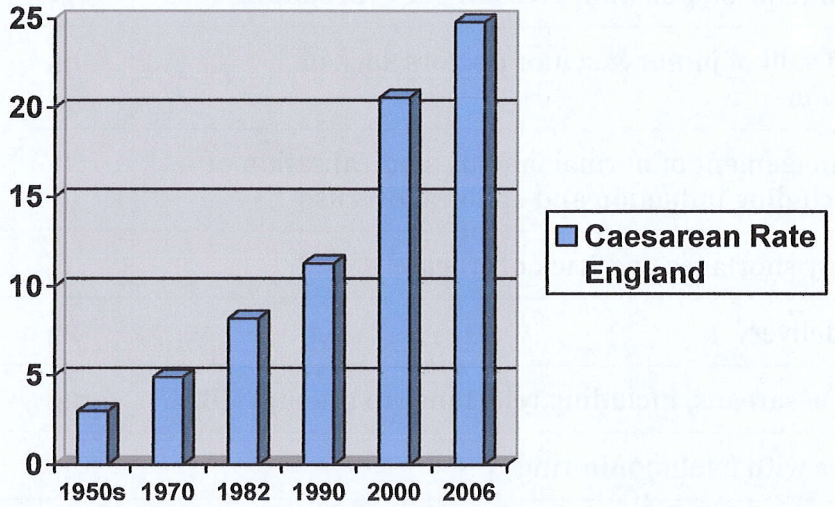
Background

Women are over four times more likely to have a caesarean birth now than they were thirty years ago and eight times more likely than they were fifty years ago. In the 1950s around three per cent of births were by caesarean.[vii] By 1973 the estimated caesarean rate for England and Wales was 5.3% and latest data shows a rate for Britain in 2006 of almost 25% (24.8).[viii] Thus there is no doubt that the caesarean rate is rising



Previous research has concentrated on women's experiences of caesarean birth and obstetricians' views of rising caesarean section rates.[ix] [x] What is missing from the literature is an examination of Midwives' views on rising caesarean section rates. Presented here are preliminary analyses of data on Midwives' views on why the caesarean rate in Britain is rising and a comparison of those views in relation to the views of Obstetricians.

Methodology

In a previous study of Obstetricians' views on caesarean section rates we circulated a postal questionnaire to all (231) clinical directors in obstetrics and gynaecology listed by the Royal College of Obstetricians and Gynaecologists in the British Isles. The first mailing was followed by two subsequent mailings later in the year. We had 151 valid replies leading to a response rate of 68.3 per cent, which is an acceptable response rate.

In the current study we circulated a postal questionnaire to all Heads of Midwifery in the British Isles (218) in 2006. The first mailing was followed by two subsequent mailings in February and April this year. From the three mailings we received 179 completed questionnaires leading to a response rate of 82 per cent - an exceptionally good response rate for a survey of this kind.

Preliminary Results: Obstetricians' and Midwives' Views
We asked Obstetricians and Midwives the same question:
The British caesarean rate rose from 12.1% in 1989 to almost 24% in 2005. What do you think are the major reasons for this rise?

Table 1 Views on Rising rates: Midwives' Priorities

Views on Reasons for the Rising CSRs (%)	OBs	MWs
Litigation, defensive medicine	52	62.5
Maternal request, demand, pressure, or expectation	71	50.8
Reduced skill of junior & senior doctors, lack of supervision	45	47.5
Poor management of normal labour, medicalisation of birth, including induction and epidural overuse	11	26.8
Midwifery shortages and Lack of 1:1 care	8	26.2
Breech delivery	23	19.5
Repeat caesareans, including reluctance to attempt VBAC	20	17.8
Problems with fetal monitoring	5	10.6

Main differences between Obstetricians' and Midwives' views
There is much agreement regarding the effect on caesarean section rates of:

- The reduced skill of junior and senior doctors and lack of supervision of junior staff.
- The management of breech delivery.
- The use of repeat caesareans, including reluctance to attempt vaginal birth after caesarean (VBAC)

However, differences begin to emerge in terms of importance placed on:

- Litigation, defensive medicine
- Maternal request, demand, pressure, or expectation
- Medicalisation of childbirth
- Midwifery shortages and Lack of 1:1 care

Defensive practice and fear of litigation
The highest number of midwives gave this as reason for rising caesarean section rates (62.5%), compared to 52 per cent of obstetricians (which is still very high).

Some of the comments from midwives were that the caesarean rate is rising because of:

'Increasing fear of litigation has made for a lower threshold in decision making.'

'Defensive obstetrics.'

'Litigation culture leading to defensive practice.'

Maternal request, demand, pressure or expectation.
The largest difference in opinion between midwives and obstetricians was on the effect of maternal request on the caesarean section rate. Midwives do not appear to believe that maternal request is pushing up the caesarean rate to same extent as Obstetricians (71% Obstetricians – 50% of Midwives).

Some comments from midwives were that the caesarean rate is rising because of:

'Offering women more choice in mode of delivery.'

'Patient choice for elective caesarean section.'

'Maternal request, e.g. previous LSCS demanding second LSCSC for subsequent baby.'

'Women requesting caesareans due to 'celebrity' demand.'

'Consultants find it difficult to say 'No' to women.'

'Choice. Popularisation/Media coverage.'

Medicalisation of childbirth and poor management of normal labour, including induction and epidural overuse

26.8 per cent of midwives gave this as reason for the rising caesarean section rate compared to 11 per cent of obstetricians. This *may* indicate that it is not perceived to be as much of a problem by obstetricians as it is by midwives.

Typical comments from midwives were that the caesarean section rate is rising because of:

'Dominance of the medical model for the past 30+ years. Increased in the 1990s due to obstetricians being afraid of loosing power when midwifery led care was demonstrating positive results.'

'Medicalisation of childbirth leading to increased intervention.'

'Increased intervention leading to unnecessary caesareans.'

'Low-risk women giving birth in obstetric units where whole atmosphere and environment is difficult for normal birth.'

'Powerful medical model for childbirth and the organisation of maternity services.'

Another respondent added:

'We need to reduce intervention e.g. inductions and epidurals. We should be aiming for normality in labour to have normal outcome.'

Midwifery shortages and Lack of 1:1 care
This was given as reasons by 26.2 per cent of midwives but only eight per cent of obstetricians. Again this could potentially point to higher sensitivity to women's needs amongst midwives.

Typical comments from midwives were that the caesarean rate is rising because of:

'Lack of 1:1 care and support in labour by midwives.'

'Shortage of midwives and not being able to provide 1:1 care for women in labour.'

'Lack of continuity of care 1:1 in labour.'

One respondent added:

'Resources need to be shifted towards midwives to ensure 1:1 care in labour.'

Others said:

'We need more midwives on labour wards. Staffing has been cut in many areas. 1:1 care in labour hasn't been taken seriously.'

'We need to increase the role of the midwife in the labour ward so she can provide 1:1 care.'

Conclusion
There is much agreement between Obstetricians and Midwives regarding the reasons for rising caesarean section rates. Midwives may be more concerned about women's experiences of childbirth, for example: the medicalisation of childbirth and lack of one-to-one support during labour. Differences in views may be analysed in terms of differences in professional culture and approach or possibly gender theory.

Predictors of 10 year outcome in functional psychosis

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ABSTRACT
Objective: Predictors of outcome for psychosis are poorly understood. Duration of untreated psychosis (DUP) may predict short term outcome although its medium to long term role remains unclear. Neurodevelopmental indices such as pre-morbid function and/or neurological soft signs may predict longer term outcome. We aimed to assess the impact of a range of clinical and demographic variables on long term outcome of a geographically-defined epidemiological first episode psychosis (FE-P) cohort. *Method*: A 10 year follow up of a consecutively presenting sample of 109 cases of first episode psychosis was undertaken. Baseline assessments included symptoms, DUP, soft signs and pre-morbid functioning. Multidimensional outcomes were assessed blind to baseline data. *Results*: Poor 10 year outcome was predicted independently by poor pre-morbid functioning, baseline negative symptoms and DUP. In a DSM-IV non-affective psychosis sub-group, outcome was predicted by poor pre-morbid functioning and neurological soft signs. *Conclusion*: Neurodevelopmental indices are better predictors of poor long term outcome in FE-P than either presenting symptoms at onset or DUP. This is especially true when analysis is restricted to individuals meeting lifetime diagnostic criteria for schizophrenia/schizo-affective disorder.

INTRODUCTION

Functional psychosis in general, and schizophrenia (SZ) in particular, has a variable outcome. Robust predictors of this have been difficult to establish: demographic, pre-morbid, symptom-related, cognitive and treatment-related variables have all been mooted. However, outcome studies are often limited due to initial selection bias; brief follow-up period, incomplete follow-up rates, restricted outcome measures and shortcomings in statistical analysis. Ideally, such studies should be based on first episode psychosis cases (FE-P) from an epidemiological sample. Poor behavioural functioning before illness onset and the presence of neurological soft signs, are known to be increased in schizophrenia and have also been proposed as risk factors for poor outcome [1,2]. Unfortunately, only a few of these studies have recruited epidemiological FE cohorts and their problematic methodologies make interpretation difficult.

Early clinical features of psychosis predicting poor outcome, such as an unequivocal diagnosis of schizophrenia rather than affective disorder and the presence of a negative syndrome early in the illness have also recently been confirmed [3,4]. However, the independence of these factors has been questioned since each may exert its effect partly through an association with a pre-existing biological vulnerability. This might also be true for the observed

association between duration of untreated psychosis (DUP) and outcome [5,6], with at least one recent meta-analysis [7] suggesting that DUP's predictive role is mediated by its consistent covariation with the apathy/anhedonia negative symptom dimension. The problem of establishing independent risk is inevitably further compounded if other known, putative, or even possible factors are excluded, a priori, from a study's protocol.

Longitudinal studies are notoriously difficult to undertake but, in an effort to circumvent *some* of these pitfalls, we report here a prospective study of ten year multidimensional clinical and functional outcomes in a geographically defined sample of individuals with first episode psychosis. The aims of the study were (i) to test previously reported predictors of long term outcome such as the presence of a negative syndrome; (ii) to examine the effect of pre-existing markers of neurodevelopmental compromise, specifically pre-morbid functioning and neurological soft signs, in predicting outcome; and (iii) to examine whether DUP was associated with aspects of long-term outcome and, if so, whether this association was independent, or alternatively, mediated by one or more of the other risk factors.

METHOD (abbreviated)
Our FE-P cohort was recruited between early 1987 and late 1989. All adult admissions to NHS psychiatric units in south and central Manchester, UK, (catchment area then 307,000) were screened; generating 111 psychosis cases (2 refusals to participate): (mainly SZ (n=69) and bipolar disorder [BP] (n=25); unipolar depression excluded). [A leakage audit at 2 yrs indicated no missed cases to that point.]

During index admission, a detailed clinical assessment was undertaken and a comprehensive social/psychiatric history was established for each patient. Other measures included DUP and soft signs (SSs). A heuristic pre-morbid index (PMF) based on academic and work performance, social and sexual relationships and forensic history, was established for 107/109 participating patients. This correlated well with scores on the full pre-morbid assessment scale (PAS [8]) in the sub-sample (of 69) for whom both indices were available, suggesting that PMF showed good concurrent validity.

All 109 patients were traced on average 127 mths (range: 114-150 mths) after index admission. Lifetime DSM4 diagnoses were assigned at f/u either from interview or chart review by consensus (CW & SL). 11 of the cohort had died (10 non-natural deaths).

Detailed clinical, behavioural and functional data was collected for the re-interviewed group covering the entire post-FE period. Follow-up measures included SANS [9], SAPS[10], SADS-L[11], WHO life-charts[11] and GAF scales[12] (to assess symptoms, behavioural functioning and service dependency). Summary data from a 10-item GP questionnaire &/or case-notes was collected for the remainder. The GPQ sought details of treatment, service contacts, and work/social functioning during f/u; and was applied to the entire cohort to provide a common summary binary outcome index (poor: not poor).

RESULTS (abbreviated)

1. Cohort descriptive statistics.

The index admission sample comprised, for the most part, young unmarried patients (see table 1 for summary details). There were no statistically significant differences for any of these variables between subjects interviewed at follow-up and those who were not. The mean DUP for the whole sample was 29 weeks (median=8 weeks).

Table 1: Diagnoses and demographic details.

		Whole of cohort	Subjects interviewed at follow-up?		
			Yes	No	p value
Number		109	69	40	
Gender	Male/female	1.3	1.1	1.9	0.27*
Age at first admission	Mean (sd)	27.44 (7.63)	27.70 (8.49)	27.00 (5.95)	0.79*
Age at first psychotic symptoms	Mean (sd)	26.92 (7.79)	27.24 (8.64)	26.36 (6.08)	0.80*
DUP (in weeks)	Mean (sd)	28.85 (42.14)	24.68 (35.71)	36.13 (51.16)	0.22*
Diagnoses – Lifetime DSM-IV n (%)	Schizophrenia.	66 (60.6)	40 (58.0)	26 (65.0)	
	Schizophreniform Disorder.	4 (3.7)	2 (2.9)	2 (5.0)	
	Brief Psychotic Disorder.	1 (0.9)	0 (0.0)	1 (2.5)	
	Schizoaffective Disorder.	9 (8.3)	7 (10.1)	2 (5.0)	
	Bipolar Disorder.	26 (23.9)	19 (27.5)	7 (17.5)	
	Major Depressive Disorder with psychotic features	3 (2.8)	1 (1.4	2 (5.0)	

* all non significant

2. 10 year outcome descriptors

In the larger surviving psychosis sample on whom comprehensive 10 year outcome data were available with or without interview (n=98), 80% had been in contact with mental health services in the previous year and 76% had been in contact with mental health services for 8 or more of the past 10 years. 18% had had no further psychiatric inpatient admissions; 18% had 10 or more. 19% were in full or part-time employment at follow-up; 48% had never worked and 16% had worked for 8-10 of the previous 10 years.

Table 2: Pattern matrix for outcome measures at 10 years (Emboldened values indicate principal loadings)

	Factor 1* functional outcome	Factor 2* service dependency		Factor 3** outcome symptom burden
GAF disabilities	**-.89**	-.06	GAF symptoms	**-.90**
SADS-L sickest level of functioning in last month	**.80**	.05	SAPS positive symptoms	**.65**
SADS-L outcome since last episode	**.78**	.04	SANS negative symptoms	**.80**
Last 24 months life chart: independent living	.09	**-.92**	Negative symptoms in last 24 months	**.87**
Last 24 months life chart: months in work	**-.74**	-.04		
Last 24 months life chart: receipt of pension	**.73**	-.12		
Last 24 months life chart: months in hospital	-.03	**.93**		
Last 24 months life chart: number of admissions	.19	**.56**		

* rotated factor solution

** unrotated factor solution [only one factor]

3. Analysis of outcome in relation to baseline predictors

Forward stepwise conditional logistic regression was performed with the dichotomised outcome measure ("poor"-"not poor") as DV and DUP, PMF, positive, negative and depression baseline symptom scores, soft signs and age of onset as IVs, in the sample of 94 surviving patients for whom all these data were available. Poor PMF was the best predictor of poor outcome (Wald= 14.97, $p<0.001$) with long DUP adding significantly to the regression equation (Wald = 10.24, $p=0.001$).

Age at onset and onset depressive symptoms were eliminated from subsequent analyses having failed to contribute to the regression equation. Linear regression was then undertaken to assess the effects of the remaining pre-selected baseline variables on 3 factor-analysis-derived outcome measures reflecting functional outcome, service contact and symptom burden in the interviewed functional psychosis group ($n_{max} = 69$). Poor 10 year functional

outcome was significantly predicted by poor PMF (t= 3.11, p<0.01), onset positive symptoms (t= 2.80, p<0.01), and onset negative symptoms (t=2.06, p=0.04). PMF alone explained 25% of the variance ($F_{1 \text{and } 64} = 21.52$, p< 0.001). Positive and negative symptoms explained an additional 6% and 5% of the variance respectively ($F_{2 \text{and } 63} = 14.39$, p< 0.001 and $F_{3 \text{and } 62} = 12.05$, p< 0.001). Service contact/dependency was predicted only by poor PMF (t= 2.10, p=0.04) accounting for 7% of overall variance ($F_{1 \text{and } 64} = 4.45$, p= 0.039). Symptom burden was predicted by poor PMF (t=2.87, p<0.01) and longer DUP (t=2.69, p<0.01). PMF alone explained 16% of the variance ($F_{1 \text{and } 64} = 12.23$, p=0.001), with DUP accounting for a further 7% of the variance ($F_{2 \text{and } 63} = 9.07$, p< 0.001).

For the subgroup with a lifetime diagnosis of schizophrenia/schizo-affective disorder ($n_{max} = 49$), poor functional outcome was significantly predicted only by poor PMF (t=2.88, p=0.02) accounting for 12.4% of the variance ($F_{1 \text{and } 48} = 6.21$, p= 0.017). Symptom burden was predicted only by soft signs (t=2.14, p=0.03) accounting for 8.7% of the variance ($F_{1 \text{and } 48} = 4.17$, p= 0.047). No baseline variable predicted factor 2 (service contact/dependency). (See table 3).

Table 3: Linear regression analyses of PCA-derived factor scores for all interviewed psychosis cases (n_{max}=69) and the non-affective psychosis sub-group (n_{max}=49).

All interviewed psychosis cases (n_{max}=69)		
factor 1 functional outcome	factor 2 service dependency	factor 3 outcome symptom burden
PMF: (beta=-.363 t=3.21, p=0.002) onset negative symptoms: (beta=.284. t=2.78, p<0.01) onset positive symptoms: (beta =.263, t=2.32, p=0.02)	PMF (beta =.255, t=2.11, p=0.04)	PMF (beta =.382, t=3.43, p=0.001) Log DUP (beta =.252, t=2.23, p=0.027)
\Non-affective psychosis cases only (n_{max}=49)		
PMF (beta =.352, t=2.49, p=0.017)	n/a	Neurological soft signs (beta =.294, t=2.04, p=0.04)

4. Intercorrelations of baseline measures/outcome scores

The regression analyses reported above should be considered in light of both the pattern of bivariate correlations between baseline variables themselves, and between baseline variables and outcome factor scores. Correlations within the functional psychosis group are shown in table 4a and indicate that PMF was correlated with onset negative symptoms, and all three of the outcome factors, whereas DUP correlated only with the symptom burden factor score, and not with any of the other onset measures. Bivariate correlations between factor scores and baseline variables are shown in table 4b.

Table 4a: Bivariate correlation matrix of onset/baseline predictor variables in the cohort interviewed at follow up (n_{max}=69)

	Log DUP	Neurological soft signs	Onset negative symptoms	Onset positive symptoms
Neurological soft signs	-0.197	1		
Onset negative symptoms	0.177	0.041	1	
Onset positive symptoms:	0.127	-0.316*	-0.100	1
PMF$	-0.073	-0.216	-0.442*	-0.076

* p=<0.01 (two tailed)
$ higher score = better functioning

Table 4b: Bivariate correlations between outcome factor scores and onset predictor variables in the cohort interviewed at follow up (n_{max}=69)

	Log DUP	Neurological soft signs	Onset negative symptoms	Onset positive symptoms:	PMF
Factor 1: Functional outcome	0.234	0.130	0.366**	0.293*	-0.484**
Factor 2: Service dependency	0.039	0.217	0.100	0.133	-0.252*
Factor 3: Outcome symptom burden	0.280*	0.240*	0.278*	0.133	-0.392**

* significant at 0.05 level (two tailed)
** significant at 0.01 level (two tailed)

DISCUSSION

3/7 of our selected predictor measures (pre-morbid functioning, DUP and negative symptoms) were significant independent predictors of dichotomised poor 10 year outcome in the larger sample in whom at least some outcome data were available. In the interviewed cohort; symptoms and PMF predicted functional outcome; PMF predicted service dependency, and PMF and DUP predicted outcome symptom burden. For the schizophrenia-spectrum subgroup, the two variables reflecting neurodevelopmental impairment, PMF and soft signs, predicted functional outcome and symptom burden respectively. Service contact/dependency was not predicted by any measure. In sum, neurodevelopmental measures rather than DUP or onset symptom profile were stronger predictors of outcome, particularly in the interviewed group, and exclusively in the schizophrenia-spectrum subset of this group. Conversely, DUP only emerged as a modest predictor of outcome in the sample as a whole. This raises important questions about the value of early intervention to reduce DUP (even before frank symptoms of psychosis appear) which is currently driving patient management strategies in several centres, notably in Australia [13,14,15].

Our results suggest that while DUP exerts a modest effect on global outcome at 10 years in the sample as a whole, this is not the case in the schizophrenia/schizo-affective subgroup. The reason for this inconsistency is unclear but may be related to the intrinsic heterogeneity of the larger former sample (which included bipolar patients who typically have more acute onsets and thus shorter DUPs) in comparison with the latter. When the schizophrenia spectrum group are considered alone, the heterogeneity of these measures is reduced leaving PMF and soft signs as the predictors of functional and symptomatic outcome respectively. DUP was not correlated with other summary baseline measures although it was significantly correlated with the anhedonia sub-scale of negative symptoms confirming Malla and Payne's findings.

The importance of onset symptoms in predicting functional outcome has recently received strong support from two prospective FE-P studies. Siegel et al [16] reported that higher levels of symptomatology in general (positive, negative and depressive) predicted poorer functional outcome 3 years later, and Milev et al [3] identified onset negative symptoms as predictors of poor psychosocial and neurocognitive outcome at 7 year follow-up. Our findings about the importance of onset symptoms (depressive features excepted) in predicting functional/behavioural outcome 10 to 12 years post-onset reinforce and extend these findings over a longer timescale.

Several methodological limitations in this study should be noted. First, despite our very best efforts, about 1/3 of surviving cases declined, or were unavailable for, prospective outcome interview, necessitating the use of indirect measures to assess functioning. Second, our baseline assessment of soft signs preceded the availability of published soft signs assessment instruments such as the CNE (Rossi et al [17]) or the NES [18]. Our battery overlaps considerably with both, but might reasonably be characterised as 'abbreviated' in comparison. Third, our 'pre-morbid function' measure was developed heuristically in order to 'capture' as many cases as possible, including those for whom assessment with the pre-morbid adjustment scale

(PAS) was impossible, and lacks rigorous evaluation. Finally, we feel obliged to note that multiple regression, upon which many similar follow-up studies in addition to our own rely, is sensitive both to the independent variables (IVs) entered and to their inter-relatedness. Its effectiveness is also limited by sample size to IV ratio, and we are aware that sample sizes for our stepwise regressions are precariously small.

It is parsimonious to expect that epidemiological risk factors for schizophrenia, such as pre-morbid functional deficits, will also be risk factors for poor outcome of the established disorder, and this appears to be the case in the current ten year outcome study. An outstanding critical issue is whether such pre-existing markers of neurodevelopmental impairment mediate their effect on outcome simply through the failure of symptoms and functioning to improve, or whether they predict, and in some way even contribute to, active progression during course of illness[19,20,21]. Clarifying these issues may open up possibilities for new ways to improve long term outcome in psychosis and schizophrenia.

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Services users: Are they the strongest or the weakest link?

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Abstract

One of the purposes of this research undertaken in one locality of the North West of England has been explore whether the local authorities promote independence among service users. By applying a model developed by Gignac & Cott (1998), the researcher worked in partnership with people with one long term condition in order to explore whether services users received more support than required (authority imposed dependence) or on the contrary, did not partially or totally receive the level of support needed for their daily life (authority not promoting independence).

The research preliminary's findings indicated that the statutory sector is not promoting independence among the services users.

The initial assumption that service users are at the heart of social policy formulation lead the researcher to commence this study based on inaccurate premises. Particularly, the researcher observed that the local authorities did not appear to take into account their clients' point of view when formulating future plans in the service provision. Despite the 'politically' correct discourse, it is bureaucrats who ignore their real clients' needs the ones that take decisions. The situation described above may take place as most of the service users lack information and ignore their rights. The local voluntary sector which is meant to fight for their members' well being, end up feeling lured by the imaginary sharing of power when invited to meetings with the local authorities. The unfortunate result is that service users are neglected by both the statutory and voluntary sector. For some of the reasons mentioned above, it is suggested that service users are the weakest link with the rights and potential to be the strongest ones. Despite this discouraging framework, proposals such as services users conscientisation, authorities empowering service users and politician effective representation are suggested to be the way to change the current status quo.

Planning for the Health and Social Care Needs of Economic Migrants: the case of New Migrant Poles in Crewe

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Abstract
This paper discusses the initial stages of qualitative research into the health and social care needs of economic migrants; focusing specifically on the new migrant Polish community. It begins by discussing the nature of globalisation, transnational migration and the range of health and social care issues that are raised by movements of peoples. For our case study we focus upon the particular experience of Crewe in Cheshire and Polish economic migration to the area. By mapping the provision available to migrants in the areas in which they tend to live and the account given of services in important policy documents we demonstrate how provision can be hindered by general misunderstandings of migrants' health needs. Assumptions, arising out of the notion that migrant Poles are young, single and healthy understand the range of health needs of different migrant and the cultural obstacles that European migrants experience when accessing health and social care. In order to provide services that cater for migrant needs professionals need to be aware of the drivers of migration, the stressors that migrants experience and the lifestyles that are often the product of work structures and hostility within host communities.

Introduction
In Britain, as in many other European countries, immigration has both contributed to an increase in ethnic diversity and led to fears about community cohesion (McGhee 2006). Socially and politically questions have been raised about a variety of social, economic and cultural issues. Much of the recent policy interest has been in providing for what are seen as 'needy' migrants; specifically asylum seekers and refugees. However, the enlargement of the European Union has encouraged and facilitated significant population movement between member states, predominantly in the form of economic migration. Economic migration raises different issues in relation to health and wellbeing from those affecting refugees and asylum seekers and in many ways. This paper is about researching economic migrants' health needs, specifically focusing upon the needs of one migrant group – new migrant Polish (NMPs) – in relation to health and social care.

Here we report the findings of two related research projects being carried out with the NMP community in Crewe; the first project's key concern is social cohesion and has involved participative ethnographic and qualitative work. Whilst initially focusing on social cohesion and inclusion, issues of general wellbeing and health have also been essential to this project because they are issues raised by the participants themselves; in particular wellbeing and lifestyle are key themes in the research data. The researchers have worked

within the community, building trusting community relationships since spring 2006; attending social gatherings, meeting with a range of migrants, and often offering practical advice as part of the reciprocal research relationship. Much data collection has occurred at weekends and evenings, in participant's own homes, based around their difficult work schedules. Health and wellbeing is of prime importance to migrants because if you are unhealthy you cannot work and thus cannot stay in the UK. New migrants also cannot gain benefits within the UK social security system (they must work for at least 18 months before being able to apply for such benefits), a fact that is often misunderstood by the public and media alike and which again makes ill health and sickness an unattractive option for newcomers to the UK. The second project focuses specifically upon the perceptions of local health and social care professionals who work within Crewe. This is a semi-structured interview based project that has also involved some observation and discussion with migrants themselves. A key question for this study is whether migrants constitute a specific group for health policy, and thus warrant distinct health service provision. Data from these two projects is presented here to examine the provision of services within Crewe and the difficulties and obstacles in providing culturally sensitive health and social care.

Globalisation, Migration and Policy

Globalisation is a phenomenon that has had considerable impact on the health and wellbeing of populations across the globe. The sociologist Scholte (2000: 15-17) identifies 5 key aspects of the phenomena. First, internationalisation in which cross-border exchanges have become more commonplace and this often relates to trade relationships that are interdependent. Second, globalisation sometimes refers to *liberalisation* of borders; quite literally moves towards more open national boundaries and easier travel and people exchange. Third, the term can relate to growing use and popularity of cultural artefacts or objects across the world, such as television and forms of telecommunication. Fourth, globalisation is sometimes used as shorthand for *westernisation* and the way structures from western societies have moved into other cultures (often with the implication that these other cultures are damaged by this process). Finally, globalisation can be construed as processes that *undermine traditional time/space relationships* so that events in one part of the world might affect others thousands of miles away. Again, a key issue here is interdependence and connection between disparate physical spaces and groups of people. As Karl Jaspers (cited in Albrow 1998:75) notes, 'the decisive thing [about globalization] is that there is no more 'outside'. The world closes'.

Under conditions of globalisation world societies experience increased flows of goods, ideas, technology, money and labour. Even though they are processes of a global scope, their effects are experienced at the local level of personal or community life. Expansion of new technologies (such as Internet, GPRS), global means of transportation, transnational entities (for example the EU), deindustrialization of high-income countries and capitalist trade competition all facilitate transnational migration. The latter, in turn, contributes to the emergence of multi-ethnic societies and Diasporas. As such it also entails new challenges and problems for local communities, governments and organizations and for migrants themselves who are

vulnerable within these changes. The forces of globalization regulate economies; they impact job availability and patterns, food prices, household income and social determinants of everyday life.

There are within these changes forms of migration that have obvious and devastating consequences for those affected; for instance, forced migration in terms of those who seek refugee or asylum status has been noted to cause a variety of psychological and physical problems for these migrants. Likewise, trafficking and modern slavery have long-term negative effects upon individuals affected. Such individuals arrive at other national boundaries with a variety of needs including physical, psychological and emotional injury from displacement, abuse and torture and malnutrition and disease. Work on supporting these groups is visible within the community psychology literature (Green 2002, Siddiquee and Kagan 2006, Webster and Robinson 1997). But the needs of 'economic' migrants is not so widely acknowledged; the assumption being they have moved by choice to seek a better life and so their needs are not so pressing.

Chosen migration can be seen as a natural product of globalisation as people are able to consider the world in terms of relocating and establishing themselves as workers. But, the notion that people choose to move masks a range of social and psychological issues that act as 'push' factors and which may follow the individual into their new society. Economic migration is a misleading descriptive term used to account for the movement of people from countries like Poland to the UK, Germany, and Sweden etc (Dipaolo and Lee-Treweek 2007). However, as a term it also narrows our understanding of what actually drives people to go elsewhere and this is often underpinned by other (hidden) concerns; a wish to escape familial or issues at home (family breakdown, poverty, abuse) or attempts to start anew after difficult times (for instance after long term unemployment, incarceration, diagnosis with a mental health problem or after stigmatisation within one's own country, such as experienced by the Polish gypsy community). As Chambers (1994:2) notes migration can be a form of 'picking a quarrel with where you come from'; a contingent act in which choice is framed by a variety of factors over which people often do not have much control. For some that choice is more a desperate need to escape other factors. More positively, but not without its own stresses, is the wish to migrate to take a new identity (such as those who cannot practice the sexuality they wish in the home country, or female migrants who hope that Europe may offer the chance of greater equality, both at home, socially and at work). Other 'chosen' migrants see the move as a form of travel and mind-broadening opportunity; a chance to learn English and engage in personal development as a tourist.

Whatever the reasons behind 'economic' migration, there can be negative health and wellbeing effects for those choosing this path. Migrants are uprooting from home cultures which, although possibly less profitable for them in job terms and challenging in terms of other aspects of their lives, may offer other comforts – cultural, kinship, social group and affiliative and so forth. The health of economic migrants can be in jeopardy in their new homes because of the gaps they fill in the labour market in their new countries - usually in sectors where the jobs are insecure and temporary –they often find

themselves in a worse position to those of the established host community members. The socio-economic status of migrants, and their chances of health and wellbeing in new countries, is directly dependent on the global economy and market, which in turn affects work conditions. Even if their host country has well established systems of health promotion and social care, and employs competent professionals, some of these might be beyond migrants' reach. Some features that might affect this might be their working hours and conditions that make accessing work problematic (night work, unsociable shifts, low pay, insecurity). In this respect economic globalization is an important context for the study of social determinants of health of economic migrant groups (Labonte and Schrecker 2007). Migration also necessarily leads to changing one's life in a way that can be stressful and demanding in terms of identity creation and emotional investment. Expectations of new lives can often emphasise the positive, whereas migration can often mean sticking with change that does not offer positive returns for some time. At the same time there are increasing accounts of physical dangers to migrants from host communities who neither understand migration policy nor see it as positive to their lives. Migrants can find themselves the social scapegoats for a variety of ills.

The health and social care needs of economic or chosen migrants is, as yet an under researched area and, unlike those effected by refugee or asylum legislation, the needs of economic migrants is seen to be lesser. Even between migrant groups needs may differ and 'action' plans designed for one group may not suit all. New migrants therefore will have a range of needs that they will require help with. Borough and county councils are often funded to provide support services, usually through targeted groups dealing with one migrant group (such as Polish associations, Somali support groups and so forth). However, the recently formed Commission on Integration and Cohesion has signalled a sea change in governmental thinking and practice, with a move from individual country or region based groups to the funding of organisations that will cater for all migrants in a locality or town. Whether this will address the changing needs of migrants, many of whom wish to build lives in their new countries, have families and feel part of their communities, is a moot point.

The 'Polish Invasion'

The subtitle above was the title given to a Channel 4 documentary that investigated the plight of NMP's and in many ways it sums up the social mood towards Polish newcomers since 2004. Since then, Britain has become host to an estimated 400,000 Polish migrant workers and some of their families (Home Office Statistics 2007). This migration was invited by the British government as part of the A8 country accession to the European Union. The government arranged open access for European workers, provided they register on arrival under the workers registration s scheme (WRS). The economic benefits of this policy are well documented and widely celebrated by the British Government and Gordon Brown in particular. However, the social and cultural effects, both regionally and at community and neighbourhood level are less positive, have been largely ignored by policy makers, and are only briefly considered in the Government's Cohesive Communities policy. In fact migrant workers receive very little attention in policy documents at all,

possibly because they are considered to represent less social cohesion 'problems' than other and earlier migrant groups to arrive in Britain in the past few decades. Other immigrant and ethnic groups have found themselves in the policy spotlight because of overt community tension and, in some cases aggression. For instance, in the case of several North England towns (Oldham, Blackburn and others) which experienced ethnic tension and violence since 2001, but where the immigrants are predominately black or Asian rather than European and white, the debate about social cohesiveness is open and ongoing.

Crewe, as with any other small towns has experienced disproportionate A8 migration. The incoming numbers are estimated at 3500. However, even estimating how many individuals are in the town is problematic and this figure is a conservative estimate. The problem with this is that the workers registration scheme, designed to log workers coming from the A8 accession countries, does not cover all migrants; some will not register and many will move about in ways that make conventional mapping of migration difficult. Other, less orthodox methods of mapping numbers provide some interesting insights into how numbers might vary. For instance, in one bank in Crewe there are currently just over 3,000 accounts held by migrant Poles (Lloyds TSB branch manager in communication June 2007). Whilst some of these accounts may not be active (as migrants often move back and forth from home countries on a seasonal basis), this is one bank out of four that are providing tailored services for migrants in the area, suggesting there could be many more accounts than estimated. Also if one is to believe recent media accounts Poles do not necessarily use banks (see for instance the story on '£50 notes disappear in great Polish take-away' in *The Sunday Telegraph* 24.06.2007); if this is the case then such accounts represent an underestimation of numbers. A similar problem has been found in the Berkshire town of Slough where estimates of migrant numbers were found to be inaccurately low when the council monitored residential sewerage output and from this calculated how many 'extra' people were living in the town. As with Crewe, Slough's main migrant group are new migrant Poles. And, like Crewe, Slough was unprepared for the kind of needs that NMPs would have.

This paper illustrates the way that health and social care provision for Poles is working in Crewe. In essence, we argue that migration policy has generally failed to make provision for the wellbeing of individuals who are often in a vulnerable position and lack the knowledge and social capitol to make connections to local services they need.

Incoming Economic Migrant Health States from Poland

Poland is a relatively young country in terms of its age demographic. Whilst the country is undoubtedly facing a similar aging trajectory as many other countries, the population is younger than both the UK, USA and most European countries. In statistics taken from the Polish National Statistics office 2006 the population is 38 635 144:

Age groups:

0 – 14	*16,7%* (men 3 319 176; women 3 150 859)
15 – 64	*70,3%* (men 13 506 153; women 13 638 265)
64 and above	*13%* (men 1 912 431; women 3 108 260)

Age mean:

Population	*36,43* years
Men	*34,52* years
Women	*38,49* years

Life expectancy

Population	*75.1* years
Men	*70.8* years
Women	*79.4* years

As with many developed European countries the birth rate is slowing. However, there are other factors that effect Poland but not, for instance, the UK. Rates of migration from Poland are having a drastic effect on the country. It is estimated that around 1 million Poles has emigrated or gone abroad to seek work since 2004. With adults between 20-40 those most likely to leave this negatively affects essential services, such as health care, fire services, police and even home building. It also means that the birth rate is slowing because of the migration of young women and that school services are affected as young families seek new lives.

Health and social care services in Poland are well developed but struggling with the population changes of emigration. After the transition from state control of services in 1989 a market economy in health exists alongside private provision of medicine, dentistry and other services. Problems have arisen though in terms of paying public health service personnel, who are often tempted into the private sector or migration for higher pay. This has also led recently to a series of strikes within public health that have left some sectors of Polish society vulnerable. However, in general access to medical services is much easier in Poland and there is a greater level of patient choice, for instance, it is possible to self-refer and pay for an ultrasound scan or other diagnostic test. It is also a routine to visit a medical clinic to self-refer for an HIV test or blood testing for anaemia.

General Health Issues of the Polish Population

National Statistic Office figures from Poland (2006) show that over the last fifteen years Poles self-evaluations of health have increased, seeming to demonstrate that post-communist health care, along with social changes are bringing greater health and wellbeing to Polish society. By 2006 61% of the Poland's population evaluated their health as good or very good and this improvement in state of health took place in all age groups and regions, regardless of gender. Great improvement of state of health was especially recorded among middle aged (30-50 years old) residents in many areas but women regardless of regional division report worse states of health than men. Interestingly, 46% of Polish population suffer from at least one chronic disease, or ill health problem, lasting 6 months or longer and in the under 30's group 15% claimed to have some forms of chronic health problem. Again within this group it is women, rather than men who most frequently cite morbidity. In young women (15-29) the most frequent chronic illnesses are migraines and headaches (7%), allergies (6%) and spine problems (4%). Ill young men usually complain about allergies, spine problems and discopathy.

Polish adults face similar issues to those in the UK in relation to obesity and weight management. National statistics show 1 in 3 adults to be overweight (by BMI), 1 in 8 people are obese. However, men far outstrip women in terms of being in the obese category, whereas women are more likely to be clinically underweight. Unsurprisingly, other 'weight-related' health problems, such as high blood pressure (30% of adult males) and heart disease disproportionately effect men in Poland. This is also affected by increasingly sedentary lifestyles. It is reported that the majority of Poles spend their leisure time watching television and reading newspaper; in other words non-physical pursuits. However, amongst the young physical activity is increasing with gym use, walking and other sports activity becoming more popular. 1 in 5 men age 15-29 regularly uses gyms for intensive workouts.

Adult smoking has seen a decline in the last fifteen years. However, still one third of men and a quarter of women are smokers. Comparing with National Statistics Office figures from 1996 the number of people drinking alcohol is increasing although still a sixth of men and a third of women claim that they do not drink alcohol at all. The percentage of drinking woman increased from 1996 at a rate of 7%, while among men it was 2%. Data show that not only the number of people drinking has increased but frequency as well and in particular the highest quantities of alcohol are among men in their 30-49 and women in the 15-29 age range. The type of alcohol being consumed has also change with beer replacing the more traditional Polish vodka and spirits as the drink of choice.

In terms of child health 8.9% of children's health was categorised as bad or very bad. Generally health of girls was evaluated as better than boys'. Large number of children with bad or very bad state of health lived in poorer regions affected by economic decline, such as podlaskie, lodzkie, lubuskie, and malopolskie. These are just the kinds of areas that migrants are likely to come from as they seek new lives and better futures for their children.

These kinds of issues demonstrate some of the health and social care needs that Poles may bring with them into the UK and the expectations they may have of services and how they work. In general the younger generation are relatively fit and healthy but obesity is a concern in males and under-nutrition in women. Spine problems are an issue for both young men and young women and, of course, the nature of available work to migrants in the UK may have an impact on the progression of such conditions and their treatment. In a recent media report about a banana packing company in London health and safety fears were raised about young migrant women, some pregnant, being made to lift and carry packs of bananas averaging 40kgs. The case that sparked interest was one migrant losing her baby after her doctor's written insistence that she be taken off such work was ignored by the company (BBC News, 23.05.2007). Similarly TUC research on health and safety at work has found considerably breaches in relation to use of migrant labour, with the lifting of weights and potential spinal risk being one of the most common problems (TUC Report 2007). Drinking and smoking of Polish migrants in the UK and the effect of migration upon these activities is an under researched area but one that demands attention. However, ethnographic data gathered within the Crewe community seems to indicate that both activities are ways that migrants cope with stressors – work and community based. This is coupled with greater expendable income than they would be used to in Poland meaning that accessing drink, cigarettes and other mood altering substances, including illegal drugs, becomes possible for them. On both projects there is considerable evidence that such drugs are being accessed and used within the NMP community in Crewe. Furthermore, accounts from regional police forces in relation to drink driving do show a problem with East European migrants disproportionately represented in drink driving arrests (Webster 2007).

A8 migrants were originally expected to be young, single, predominantly male (this was particularly thought to be the case in Crewe, which is largely offering employment in packing, food processing and other light industrial sectors) but significant numbers have now brought families and children to live permanently in the UK. There are also many single women employed in financial and service sectors but also in factories, food processing and packing. A study of similar female migrant workers in Bedford (Bedford family planning association reported to media sources Spring 07) flagged an alarming rise in the number of terminations applied for at the local FPC and hospital, citing this trend as an inevitable consequence of the pressures to earn a regular income, uninterrupted by pregnancy. It is possible that the catholic morality in which many of these women were raised may also play some part in these trends. Health visitors in Crewe report (Interview with Health Visitor in Crewe May 2007) that midwives in the town are also experiencing growing trends which may prove to mirror the experience of Bedford.

Health visitors in Crewe are also concerned about child protection owing to the numbers of children living in multiple occupancy households where both parents work shift patterns, including night shifts (Interview, May 07). This can mean children having contact with numerous other adults who are not well known to the parent and for such individuals being asked to provide child care services. Given the statistics from Poland in relation to poor child health

in some regions, this may also be source of concern for health providers if more migrants bring their families to stay with them in the UK. To balance this view it must be noted that the recent report by Unicef noted that the quality of childhood in Poland to be higher, in terms of quality of life and enjoyment, than that of UK childhoods. The reasons for this difference are unclear (UNICEF Report 2007)

Studying Migrant health and Social Care needs in Crewe

Crewe is a comparatively modest manufacturing town in Cheshire, which remains tied to its railway and Rolls Royce production roots. It is a small town with approximately 47,000 inhabitants who could broadly be described as a largely homogenous working class population town. Although there was some Polish migration during and after the second world war (now numbering about 600), and some small scale afro-Caribbean migration in the 1970s to work in the railway and car plants, in general the town has little history of cultural diversity. Crewe and Nantwich Borough Council have estimated an influx of 3.500 Polish New Migrants since 2004 (Ian Richardson, Crewe and Nantwich 'invest to save' manager, in communication February 2007). Crewe has been noted in the UK and Polish national press as a centre for Polish migration and the reasons for this are clear. After accession work agencies from Crewe set up offices in Poland and from these filtered workers into the labour market. At this time Crewe's unemployment rate was very low and the town could not have continued its growth in the business sector without filling jobs. Crewe's reputation grew within Poland and now it is known as a first port of call in the UK for many new migrants seeking work; not least because many are likely to have friends and relatives working in the area. Whilst these workers have benefited local business and the town there are problems in providing services that are culturally sensitive and tailored to local migrant need. Local health professionals are struggling to meet a new and not always easily identified set of health and social care needs, from a position of limited resourcing and still less preparation. Local services were unprepared for the numbers of migrants arriving within a comparatively short space of time and were forced to respond to circumstances as they arose, rather than planning for changes well in advance.

The Borough Council has had funding through the Home Office's 'invest to save' to develop a Polish Association that was envisaged to become self-sustaining in the future and to support both NMP and older Polish community needs. However, the Association has not found it easy to identify migrant needs beyond the provision of advice and information relating predominantly to housing, employment and financial matters. Personal health matters are deal with through a link community nurse who works with the Polish Association one day a month. For reasons that are not clear NMPs are often not using the Association unless they are in very serious situations and even then, some prefer to use kin and friendship groups. Unfortunately this has led in a number of cases to the lay provision of incorrect information and guidance on serious matters such as health issues, debt and accommodation.

Migrants in Crewe tend to reside predominantly in one of the six regeneration wards within the confines of the town and are therefore significant additions to local health providers. Recent research published by the Joseph Rowntree

Trust (Spencer, Ruhs *et al.* 2007)suggested that such migrants are often long term residents who settle in an area with their families and frequently hold aspirations in their adopted country not only for them selves but also for their children. They not only reside in but work, play, educate their children and demand health service in what are often neighbourhoods identified as Multiply Deprived (IMD, ONS), since these are the streets with the most affordable accommodation, and thus attractive to economic migrants.

Crewe has one PCT hospital supported by a network of GP surgeries many of which are currently (summer 2007) undergoing redevelopment and expansion of services, predominantly in the six regeneration wards. C&NBC's Neighbourhood Renewal Strategy (Bowler 2006) and Sustainable Communities Strategy both focus on key target areas for health improvement in deprived areas of the town. The Borough's Vision statement addresses health inequalities and access issues, aims to improve general health and identifies specific target areas including smoking, alcohol abuse and the rising rate of emergency admissions. It is likely, though, that migrant workers will present additional challenges to the Borough and PCT's targets for the next decade, since the albeit limited evidence so far suggests that Polish migrants are often heavy smokers, drinkers and apparently also regularly admitted to A&E at the local hospital. If numbers of migrants in the Borough continue to rise, it is even more important that data is collected to help the PCT plan for future service delivery. Crewe's continued economic expansion (Chamber of Commerce, 2007) will no doubt encourage the recruitment of more A8 workers so this is not a temporary change to the town's population. Recent research carried out by Joseph Rowntree Fund (Report 2007) suggested that migrants were increasingly likely to put down roots in their host communities rather than work for a few months then return to their source nation. This, then, would suggest a continued focus on health and social care needs is essential for the regeneration areas in Crewe and other small towns affected by migration.

'Don't believe the Hype' – policy and reality in local context

One of the key problems faced by the research team was ascertaining exactly what was happening on the ground. Crewe is held up within public policy as an example of positive services being provided for the Polish community. According to a recent Audit Commission report (Crossing Borders 2007) local health providers are offering translation services, accommodating migrants and fulfilling health and social care needs as they arise. However, initial research by the team has indicated that this is clearly not the case, and increasing evidence of this is generating alarm among health care professionals, voluntary sector workers and academics. On a visit to the local accident and emergency department the greeting in Polish on the 'welcome' board was spelt incorrectly. Information on how to get to the toilets and other important details were written in words that do not exist in the Polish language and appeared to be a mix of Polish and Welsh. The research team also discovered that translation is not routinely offered but that a bank nurse, who happened to be Polish, was called in **if** he was available in the hospital. Staff report that more often than not, the nurse was unavailable when needed for emergencies leaving staff coping sometimes with serious injuries and no means of evaluating the state of the patient.

Furthermore, there are problems in local GP surgeries which may produce leaflets but do not have access to translation services or systems in place to provide help where English language is a problem. Funding for English language classes has been available in Crewe (and other areas across the UK) but is due to expire in November 2007, after which migrants will have to pay for their classes at the local tertiary college. The take-up of free lessons has been high amongst Polish families (regular classes of ten students) but low among younger, single migrant workers who often work unsociable shift patterns. Consequently health professionals rely on English speaking family or friends of a patient to provide support which can, in many cases, constitute problems in terms of doctor-patient confidentiality. In turn this can affect help-seeking behaviour where a patient does not want another person to be aware of their health issues. This also puts stress on migrants who can speak English to effectively become informal health workers. This often becomes an expectation within the community as Serg, a 22 year old migrant commented.

> *'I am sick of taking X to doctor, if it's not him it is Y. Because I [can] speak [English] I have to do this but it's not good for me. I work nights and then I have to take others to places in days.'*

Another migrant who also found herself in this role, Gosia, a 28 year old administration worker, noted,

> *'I get angry that I have to do this for people. They come here [to her house] because they can't do it but I have a life too and it's not like a relative its someone who perhaps you know little and if you turn them away then you are bad person in community.'*

For these young Poles, they become interpreters, health workers and confidents to others who they may not have close connections with generally. Apart from the stress this must generate there are important issues about practitioner/patient confidentially. As one receptionist in a local GP commented to GLT,

> *'Some of them are very good, they bring along a friend to translate and this means we don't have to worry.'*

The assumption is that Poles will 'look after their own' and, as in this case, are 'good' for doing so. This is an assumption also noted in research with other ethnic minority communities about health needs. However, with New Migrant Poles there is the added dimension that some people use the example of the migration of Poles after the war to justify their views on how the NMP community should behave in these matters. Harriot, a nurse in accident and emergency commented,

> *'Well you expect them to look out for one another like they did after the war. I remember my mother telling me about them moving to Crewe then and they were very supportive to one another. I expect they are like that now and you do see them coming in with one who can speak for the others.'*

Of course, such romanticisation of the supportiveness of the Poles who came to the UK during and just after the second world war does not take into account subsequent social changes in Poland, different divisions and social

relationships that grew up during communism and the rapid pace of change since then leading up to A8 accession. During these periods Poland's social structure has altered and traditional forms of social network and allegiance have shifted. However, for many health and social care staff (as is the case with lay people in the UK), the 'old' Polish community in the UK may be the only model of Polishness that they have to draw upon in understanding NMP experiences. As the recent Government directive (June 2007) to reduce translated information in services, allegedly to encourage migrants to learn English, is implemented at the same time as English as a foreign language classes are reduced the problems of assumptions around 'community' members acting as advocates in health and social care settings will increase.

A significant factor hampering provision of adequate health resources is a lack of accurate data. From estimates of the total number of migrants to their medical histories health services are working on the basis of best guesses rather than actual numbers and validated information. The initial assumption that Polish economic migrants were all young, single, predominantly male and subsequently not a great burden on health service is refuted by the health professionals who find themselves in the front line service provision, dealing with infants, children, mothers and younger single migrants in our study. For instance, in an interview with a health visitor in Crewe she noted that she does not have enough time to cope with the range of issues the Poles bring to her (interview with Health Visitor, May 2007). Educational services are also under strain, in September 2006 30 primary age and 70 Secondary school students were presented for enrolment at two of Crewe's schools with little if any prior notice to the respective head teachers. Both schools have had to find and employ part time Polish speaking teaching assistants and have worked hard to facilitate the Polish pupils' integration into their schools. Sure Start and local Health Visitors initiated drop-in centres for mothers and toddlers on estates in Crewe and were overwhelmed by the take up in this provision which has now ceased to be funded (Spring 2007). This has caused concern to the personnel involved in this initiative. In terms of planning services in this area for the future the lack of day to day contact between professionals and Polish service users make the planning and building of trusting relationships highly problematic.

However, many healthcare services that treat Polish migrants and their families, from accident and emergency to Family Planning services, do not (or are not requested to) collect data on migrant users. We do not know how many Polish families, compared with previous years, are dependent upon Crewe's health and social care infrastructure. The sole Polish speaking dentist is in Winsford, a neighbouring town, and mental health provision is even more distant; the nearest Polish speaking practitioner is in Manchester. Ironically though, migrant Poles consider English dentistry, and indeed healthcare to be lower in quality to Polish services, with many choosing to accepting dental pain and other conditions until they can return to have treatment in Poland rather than being treated in what they see as a substandard health system. As Agnieszka a 25 year old factory operative noted to the researchers,

'They (UK people) think we take their services. I don't know of one Polish person who does not worry about having tooth pain here and having to see English dentist. I have waited to see my own dentist rather than find out how bad they are.'

And Marcin, a 23 year old warehouseman, who was also a keen sportsman and marathon runner argued,

'I went to see GP to get blood test to see how my training was going [as he always did in Poland] and he said, 'what is wrong with you, you only get blood test if something is wrong'. I could not understand because in Poland my doctor tells me results to improve performance but GP thought I was mad!'

As can be seen here providing services for NMP's involves recognising the great cultural differences and expectations that they have of services. It is also not the case that migrants will 'flood' services or even ask for help if they feel they cannot trust the system and do not have good communication with professionals. In Marcin's case this migrant worker read his doctor's failure to understand his wish to have a blood test as disinterest and Marcin was concerned that the practitioner thought he was being neurotic or difficult, however, it is highly likely the doctor was not aware that in Poland asking for such a test is perfectly acceptable.

Migration, Health and Deprivation

Again there is a dearth of available data about migration, health and deprivation in Crewe, however, we know where many migrants and their families live and can map the neighbourhoods which attract migrants. In common with those in larger urban residential sectors, migrant workers in Crewe find themselves inhabiting shared houses provided, sometimes by employment agencies or other times by private landlords and companies in the wards which, according to IMD data (National Statistics 2007) are not conducive to health or indeed access to health or any other services. This raises some important issues; if migrants become part of deprived communities – integrated, or assimilated in a 'cohesive' fashion – is it good for their health and do migrants living in deprived communities conform to their adopted neighbourhood's characteristics of poor health, low educational attainment, high levels of unemployment and social exclusion? In Crewe, some Polish migrants are already demonstrating similar needs to the host communities residing in the poorer wards in Crewe; those identified as Regeneration Areas (Neighbourhood Strategy, Crewe & Nantwich Borough Council, 2006). As such, migrants constitute a stratum of an existing deprived population. On top of this migrants may come with histories of deprivation from their areas of origin in Poland and, with this, particular health needs. An example from our research is those Poles who come from Polish Romany gypsy background. This group is known in the Polish health literature to have particular health and social care needs and also have often suffered discrimination and social exclusion in Poland that may also have negatively affected their physical and mental wellbeing. In this way, health and social care needs that have been unmet in Poland can be transferred to the UK where migrant lifestyles and experiences here could exacerbate problems.

Additionally, work conditions in low paid sectors in the UK raise the level of risk to which many Polish migrants are exposed. This is not always the case as in some urban areas of Britain Polish migration has, in the main, been white collar. So, in the case of Newcastle upon Tyne many professional Poles with degrees have migrated to work in professional sectors. However, in Crewe, as is the case in many small town migratory destinations, migrants work in the lowest paid and least attractive sectors of work; such as food processing, packing and logistics, warehouse labour and industrial cleaning. The nature of their employment means they are often vulnerable to potential accidents at work, as for example, documented by a TUC/SSRC, Northumbria University report (Fitzgerald 2007) which found that migrant workers are less protected by employment law than indigenous workers, more likely to do more dangerous jobs than indigenous workers, less likely to be acquainted with Health and Safety Policy and legislation and still less likely to be unionised. Research by London Metropolitan University's Working Lives Institute (McKay 2007) suggests that Polish workers disappear when accidents at work occur; if they are unable to work they return home rather than taking their employer to task; accidents thus go unreported and unnoticed by everyone except the worker involved and her/his employer. TUC/SSRC research (2007) suggested that migrant workers fail to work safely because they are not appraised of Health and Safety instructions, are often working in hazardous environments and for long shifts; a recipe for accidents.

The social cohesion study being carried out by the team in Crewe have found a prevalence of rumours and myths among the indigenous community that Polish migrant workers are preferentially treated in comparison with themselves; that they have unfair access to jobs, housing, transport and health services. In one focus group the following comments were made:

> *'My son can't get a job for [because of the] Poles. He's tried and tried but they tell him that they can get Poles cheaper and because they work like dogs then we are all supposed to ... I give them dues for working hard but they mess it all up for the rest of us who can't do 80 hour weeks.'*
> (Participant 1: female, 47)
>
> ...
>
> *'It's same with those flats, right by the limelight [club], they are all new flats and all for Poles and the cars they get for free ... As for being able to drive without insurance or tax on their cars don't get me started because its not right.'*
> (Participant 2: male 53)
>
> ...
>
> *'they just get what they want, imagine if we went to Poland and wanted to use their NHS, it'll be a different story then but they get all sorts here, including cosmetic surgery when others have to wait.'* (Participant 3: female 20)

It is worth noting that the flats referred to here are private flats for sale and are 'luxury' and therefore too expensive for average migrant wages – or average local peoples' wages either. The car tax and insurance issue had been

raised two weeks before in the local press and was wrong – Poles have to pay like anyone else. Perceptions and beliefs like these are powerful but rather than having working lives that are charmed and open up opportunities it is the case that Polish workers are more likely to be injured at work and to receive lower remuneration than their English counterparts (McKay 2007, Fitzgerald 2007). In an environment or culture of fear, Polish workers are reluctant to express concerns about employment conditions. Interview findings from the community cohesion study suggest that Polish workers in Crewe loathe to complain about employers even if personal targeted abuse takes place and in the case of some female factory workers sexual harassment and exploitation. These factors combine to make providing health services that recognise the nature of migrant workplace stressors problematic; as with many other aspects of studying migrant experiences, information on hardship, exploitation and abuse remain undocumented and is largely invisible to the legal framework, unions and even local support groups. The notion of invisibility is especially pertinent in respect of migrants failing to report unfair treatment or risky environments in the workplace. Doctors, nurses, social workers and other professionals are in a pivotal position to enlist migrants' trust in explaining what their lives are like both in the community and at work and in identifying the particular needs that discrimination and prejudice in these arenas visit upon migrants lives.

Accounts of Using Health Services and Emerging Wellbeing Issues

In Crewe most migrants live in campanisimo groups (Gio 1992), that is groups brought together through family, friend or location of origin, so that one often finds migrants from the same village or small area living together in a shared rented house. Among single working migrants job, housing and money worries can create a stressful household environment, however, living in campanisimo has an added benefit of providing support and making life more bearable. Informal support mechanisms are also available from those Poles who they are affiliated to in the surrounding area. Again, friendship, kin and locality ties are usually strong. It is unsurprising in this type of model of small knit 'bundles' of communities and groups that information about health services in the UK, and especially poor experiences of it, are passed around swiftly and can hinder the help-seeking process and trust building between health care staff and NMP patients.

Both studies have found that migrants often do not visit the doctor in the UK unless they can help it; as noted above they have a dim view of English health care and the standards of professionals within it in comparison to those of Poland. However, some migrants had tried to access services but had experienced problems that put them off using the GPs right from the start.. Indeed for some it was clear that they gave up at the first hurdle because of bureaucracy within practices as Greg notes;

> *'The lady [receptionist] she say I must have bill from gas with my name on it but I am in shared house and we do not get bill like this. She say if I cannot bring I will not [be able to] come and so I don't go doctor.'*

Bureaucratic expectations that everyone can access documentation with their name and address on can leave migrants out in the cold when it comes to services. Shared premises and house-renting arrangements that are often

barely legal mean that migrants may not have things such as bills and rent books. This problem was very commonly reported (and, incidentally, was also a finding on the BBC panorama programme on migrants screened in July). Similarly, if migrants do not register with the workers registration scheme they are unable to receive national insurance numbers and hence NHS services. For other migrants form-filling and the shame of not being able to give information in this format was a problem. As Magda argued,

> *'They expect me write address, write details but I not time to go college and I look like stupid so I take form and not go back.'*

At the point of making this statement Magda was approximately five months pregnant but had received neither anti-natal care nor advice on her pregnancy. It seemed that receptionists, as the first point of access to general practice care, were pivotal to whether migrants registered or understood the services available. Whilst many migrant's English is limited all surgeries in the Crewe area have leaflets in Polish available but clearly migrants would have to be directed to these and possibly provision made for explaining any key points. However, the accounts of migrants showed that this was not happening currently.

For some other NMPs attending for treatment, waiting for appointments and the UK GP system was so alien to their expectations of healthcare that they simply took matters into their own hands. Rafal, a 22 year old had been assaulted in the street necessitating paramedic and then hospital treatment. However, during the treatment at accident and emergency he reported that the doctor had told him the stitches needed to come out in 10 days. Unregistered with a doctor and unsure of the UK health system he had opted for an easier option than seeking medical help – taking the stitches out himself with scissors.

> Rafal *'I take them out'* (shows hand)
>
> Researcher *'You shouldn't have done that you needed to see a doctor (turns to other researcher) he's actually done quite a good job at it (turns to speak to Rafal again) You really shouldn't have done that though it could have got infected why didn't you see the doctor?'*
>
> *'I not have doctor here (waves hands in flippant manner), it doesn't matter.'*

Later one of the researchers made an appointment for Rafal to see the GP that was closest to his home but he did not turn up and his explanation was clear.

> *'I not go, I know you think I should go but I can't find [the] place and hand is OK I not need to see doctor now ... I am OK, healthy not needing doctor'*

Perhaps unsurprisingly, Rafal cannot envisage needing a doctor because he felt fine at the time of making this statement but this is also symptomatic of migrant's lifestyles where work and family/friendship group take up much of most migrants' time. In essence, most NMPs do not worry about illness and operate on the basis (and hope) that their health will hold out.

Due to such attitudes it is perhaps unsurprising that accident and emergency provision is important to migrants and used almost an alternative to GP

services when they have serious symptoms. Experience of emergency care was the most likely form of health care that NMPs reported experiencing. And even here they were puzzled by UK provision that was seen as slow. Waiting times were often viewed as indicating that the migrant was being ignored and it seemed that rarely did anyone try and make clear the process of emergency care in the UK. Tomas, like Rafal, reported that he was badly assaulted in the street by a group of local boys when walking home from work. He was taken by friends to emergency at the hospital with a head injury and severe bruising. However, he did not understand the triage system in use.

'I saw nurse and then I sat and sat and in end I got up and leave after two hours. I cannot be that bad if they leave me this long'.

He then gave an account of it taking him some weeks to recover from his beating. Physical assault was the most common reason cited to us for males needing medical care and their main point of access was accident and emergency.

There are particular health and wellbeing problems that arise out of a migrant lifestyle which suggest that health and social care professional engagement and support are actually essential to looking after the NMP community. The ethnographic work in Crewe revealed lifestyles that often excluded healthy behaviours in favour of contingent unhealthy 'live now' attitudes and beliefs about wellbeing. Whilst it would be difficult to estimate numbers from the type of studies undertaken it would appear that there is a extensive problem with aggression aimed at the Poles by the local community; especially aimed at young male Poles and usually involving physical violence but also threat in the street, verbal racist abuse and abuse within work places. Discussions in the field with NMP participants in Crewe suggested that these factors, coupled with boredom at work and a restricted leisure environment contribute to there being often little to do outside work than drink, smoke and sleep. One group of male migrants discussed their experiences of this type of narrow lifestyle.

'What is there to do? This is Crewe.'

'You go out to X bar and you have trouble so you don't go out to X bar anymore ... you go gym but it costs money, £45 out of money of £800 a month.'

'There is no life here as you cannot go out in evening but work all night and sleep all day, Germany is better. I might go back to Germany'

Researcher: *'Do you find it difficult to participate in pubs, clubs and other things because of local people taking a bad view of you?'*

'Yes, it is the young boys, teenage CHAV boys, they are aggressive and so [its best to] not got on streets, stay in [and] drink ... even here they throw stones at window because they find out we are migrants'.

At this point one migrant housemate arrived home and told the others he had bought 'chocolate', when asked by another the cost of the chocolate he said '£25'. As we had found in exchanges in the field with other migrants, it was clear that drug use was another way that the migrant lifestyle could be made bearable. This particular group of migrants all worked nightshifts and had done so for a year or more. Their shift patterns debarred them from having

social lives, as did the aggression they experienced in many local venues and instead they chose to drink and socialise at home, often at odd hours and consuming large amounts of vodka and, one would suspect 'chocolate'. Issues such as depression and anxiety may well be hidden by such behaviours and or may be fuelled by substance misuse coupled with daily experiences of neighbourhood and workplace abuse.

In some cases we collected reports that NMPs were spending over half of their expendable income on drink and/or illegal drug use. There were also numerous reports and admissions to the researchers of anabolic steroid use within the male NMP population, both to help with work (to make one bigger and thus more able to handle the type of heavy labour meted out by employers) and to act as a deterrent to potential neighbourhood attackers. All of these areas; drink, drug and risk taking behaviour, need further and urgent research attention[1]. Meanwhile risk taking behaviour will be storing up potential health problems for migrants in the future and for health services either here or in Poland. Given the increasing numbers of NMPs wishing to stay and settle it would pertinent for health and social care services to recognise that substance misuse presents a hidden issue within the NMP community that demands attention and outreach work.

Here we have highlighted three key issues for health and social care provision in Crewe to demonstrate how migrants' needs may differ from established local communities. First there are the set of issues around signing up with services, understanding processes, being made welcome in services and dealing with staff who have a good grasp of the cultural differences between Polish healthcare and the UK system. Second, there are issues around the way some services become alternatives for particular communities; here accident and emergency is pivotal to service provision for NMPs because it is the 'last resort' they seek when really ill. Dealing with trust and other issues between GPS and NMPs would alleviate stress on this system but in the meantime accident staff has to be made aware of how important their role is to migrants seeking care. Lastly, migrant lifestyles are often contingent and chaotic with growing ethnographic evidence of drink and drug use from our studies, along with work conditions that can create both physical and psychological stress (which in turn feed risk taking behaviour). As a final note it is work remembering that most NMP are young people (18-30) who do not necessarily rate the importance of long term health, in favour of a hand to mouth approach to daily living. All of these factors mean that their health and social care needs may in future increase due to the possible long lasting effects of such lifestyles.

Conclusion

In this paper we have tried to highlight debates around economic migration and health and wellbeing whilst also indicating the way that NMPs living in Crewe, a small town subject to intense migration, are experiencing health and other services. We have predominately focused on health issues here but there is a need for social service support, especially as the NMPs increasingly bring and start families in the locality.

[1] The research team are currently focusing upon developing these areas for further research funding.

Economic migrants have often been missed out in research about health and social care provision because they are considered to not be as 'needy' as other migrant groups. However, this does not mean that they do not require support or that issues of culture and difference are not important in delivering services to them. Indeed, it could be argued that their needs are often invisible; often hidden behind assumptions that economic migrants will automatically know how to find help and will understand the receiving society's health and social care system. Here we have indicated some of the ways in which such systems are confusing to economic migrants to the UK and how they may choose to avoid seeking help because of this. At the same time living in a hostile environment may lead migrants to have other problems that require specialist input such as drink and drug problems, sexual health awareness, injury from assault and psychological difficulties from experiencing extended racist abuse within host communities. Living almost a twilight existence many migrants have little contact with those professionals who could help them address these issues. Moreover, in small towns, such as Crewe, there is not the plethora of services available in cities and urban locations that might serve some of the new migrant community. There is clearly a role for health and social care services in supporting new economic migrants. These newcomers represent complex issues but professionals need to consider whether they could be better served by more tailored services that involve outreach and participation within the communities.

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The Way We Are Now

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The innovatory research on 'The Way We Are Now' uses new technology (mobile phone/camera/recorder) and an experience sampling method to record visual experience and well-being. This will be a useful addition to ways of monitoring, and understanding, change and well-being. It is also a new approach to 2D and 3D portraiture. The practice led research also aims to reveal insights into the nature of creativity. Details of the project and examples of the research and art work undertaken will be posted on the website www.creativity-embodiedmind.com The website presents material from previous research by the author into embodied mind, technology and creativity, funded by the Arts and Humanities Research Board in the UK, which underpins the current research on The Way We Are Now. This research also draws on research into well-being by the author, some of which is presented on the website www.wellbeing-esrc.com funded in part by a grant from the Economic and Social Research Council in the UK.

Research Context

A paradigmatic change is now occurring in our conception of what it is to be a human being in the world, and how we come to understand things and act in innovatory and creative ways. Lakoff and Johnson (1999) in their book 'Philosophy in the Flesh: the embodied mind and its challenge to western thought' emphasise that the mind is inherently embodied. They stress that thought is mostly unconscious; and that abstract concepts are largely metaphorical. They discuss in detail how the body and the brain shape reason, contrary to traditional Western Philosophy which sees reason independent of perception and bodily movement. The authors acknowledge their indebtedness to Merleau-Ponty and his embodiment theory of perception. However, unlike Merleau-Ponty, they do not examine the importance of the interaction with materials and the role of technique in helping to shape consciousness. Merleau-Ponty (1964 a) claimed 'that modes of thought correspond to technical methods, and that to use Goethe's phrase, 'what is inside is also outside' (p 59). This claim for the intertwining of thought and technology, is now supported by the writings of anthropologists who view technology as skilled practice (e.g. Harvey 1997).

Merleau-Ponty represented knowing and understanding (cognition) as embodied action. In the 'Phenomenology of Perception' Merleau-Ponty (1962) argues that our fundamental knowledge of the world comes through our bodies' explorations of it. The body is not primarily a thing observing the world and being informed by its motivational and emotional state. Instead, primary meaning is reached through co-existing with the world in distinction to intellectual meaning which is reached through analysis. Primary meaning is brought about mainly by pre-reflexive thought in distinction to reflection. Meaning is not found pre-existent in the world, but called into existence by bodily activity, with inter-subjectivity resulting from the communality of the body. Equally, the embodiment theory does not negate the importance of reflection. Merleau-Ponty stresses that it is the unreflected which is understood and conquered by the reflective, and that left to itself perception forgets itself and is ignorant of its own accomplishments.

Scattered throughout the writings of Merleau-Ponty is an embodiment theory of art, which he uses to support his embodiment theory of perception (Haworth 1990,1997). This views the artwork as 'enriched being' in its own right, as distinct from an analogue for an external truth or essence, as traditional aesthetic theory claims. It 'gives visible existence to what profane vision believes to be invisible' (Merleau-Ponty 1964, p 166). It contains 'matrices of idea' and symbols whose meaning we never stop developing (Merleau-Ponty 1964 c, p 77).

The writings of Merleau-Ponty constitute a route to follow, rather than a finished theory (Le Fort 1968) Along with analysis by other authors (eg Gray 2004, emphasising the importance of unconscious thought, and Howes 2005, documenting the turn towards the importance of senses in vision) they present a new paradigm for understanding and action in the world. This recognises intersubjectivty through the communality of the body, and the important role of all the senses in creativity, viewed not a search for absolute unchanging truths, but ideas and forms in which we can come to rest provisionally.

The AHRB funded research by Haworth into the interplay between mind, body and electronic technology in fine art shows the value of adopting this new paradigm (www.creativity-embodiedmind.com). The research shows that the fusion of thought and action is critical to the creative process (Haworth 2005). The research also highlights the importance of studying freedom and constraint in the creative process (Haworth et al 2005, Haworth 2006); which is pertinent to our understanding of the dynamics of our interactions in the world.

PROJECT

The Way We Are Now

The project has a particular focus on the use of new technology with an innovative method. The new technology is the Sony Ericsson K750 mobile phone/camera/recorder. The innovative method is the Experience Sampling Method (ESM) extended to include images, which has not been done before.

The ESM involves a series of short questions being answered on a card, and a photograph of the surroundings taken, at a signal from the mobile phone, eight times a day at randomly selected times between 9.30 am and 9.30 pm, pre-programmed in the phone, for seven consecutive days. The questions are on activity, enjoyment, interest, challenge, skills, visual interest and happiness. The questions on activity and subjective well-being have been used previously in research with the ESM. (e.g. Clarke and Haworth, 1994; Haworth and Evans, 1995; Haworth, Jarman, and Lee, 1997)

With the exception of the question on the activity being undertaken, answers are chosen from pre-coded alternatives, making recording on a card simple: for example

Q4 How challenging did you find the activity

1	2	3
Low challenge	Moderate	High

Q6 How visually interesting did you find the scene

Low interest	Moderate	High

There is a small space on the card for any comments at each signal. At each signal, brief comments are also recorded on the mobile phone.

Each day a photograph is taken of a heading to an article in the Guardian, the Sun, and the Lancashire Telegraph. The papers are saved from the week, and material can be selected at a later date.

The previous is downloaded into the computer to provide the raw material for the creative production of large-format, and smaller, prints.

A qualitative evaluation is also made of how typical the week of the ESM was for the participant.

The investigation has been undertaken for one week in each of the four seasons of the year. At least one large-format print (42 inches x 65 inches) will be made for each season, as well as smaller prints. Some of the prints will incorporate colour codings of the answers to each ESM signal.

The print for autumn 2006 is shown in Figure 1 (here)

A cylinder print on transparent plastic will be made. The circumference of the cylinder will be 42 inches and have on the upper part the modified images taken from the newspapers. The seven vertical strips of images, one for each day will have further graphic work associated with them related to the questions in the ESM study, details of which are given in the appendix. Each day will form a tube in the overall cylinder. The outside of the cylinder will also have graphic work on it based on the life history of the person doing the ESM. The idea for the cylinder is based on modern theories of the brain and consciousness, relating to information processing occurring in tubules in nerve axons.

In parallel with the ESM project, a digital camera is used to take pictures of the season for use in making separate prints. A log is kept of both the technical and thought processes involved in making the prints, paying particular attention to insights into the interaction between technology, perception, and the creative process. The log has proved to be an invaluable method of research in the previous AHRB funded projects. First person methods of research are now strongly advocated (e.g. Varela and Shear, 1999).

A presentation on the project will be made at the IMPACT 5 International Printmaking Conference in Tallin, Estonia, In October 2007. This conference has a theme of focussing on Slices of Time, with encouragement to produce a political-poetic statement. The current project, combining selected text and images from newspapers, including the political, with images of daily life, suitable processed using Adobe Photoshop, aims to do this in relation to The Way We Are Now. Work from the project will also be presented on the website www.creativity-embodiedmind.com

A similar project, based on the above project, has been undertaken by several members of staff at Manchester University. This has been organised by Anne Kellock with the guidance of the author. Prints for each person were exhibited, along with one for the author, at the RIHSC Conference. They generated considerable interest. It would be very useful to undertake new studies with different samples of people in different circumstances, and also undertake longitudinal studies to asses change. This would be a valuable addition to the increasing interest in the use of visual methods in research (e.g. Mason 2005)

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